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Sylhetisation, Dependence and Ambivalence: A Qualitative Exploration of Paan Use Amongst Older Bangladeshi Women in London

JANAKI MAHENDRAN

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ABSTRACT

This thesis introduces a novel and alternative way of understanding paan addiction among Bangladeshi women by exploring their lived experiences. There is growing medical evidence that Paan, a mixture of betel leaf, areca nut, tobacco and white lime, is injurious to health, causing cancer, oral disease and addiction (WHO, 2004). Paan use is prevalent and visible among the Bangladeshi community in East London. However, paan dependence is principally examined through the dominant medical model, which prioritises the scientific and pharmacological aspects. Research has yet to examine paan dependence from the user's perspective, which limits health and social care professionals from understanding the practice, the determinants of the habit and the elements contributing to its continued use. Understanding the user perspective would assist in designing and delivering appropriate and targeted interventions. There are no similar studies of this nature into paan use and therefore this study developed a theoretical framework by examining literature pertaining to migration, biographies and inequalities of health.

Method: An ethnographic study was conducted and data collected through extensive fieldwork followed by in-depth interviews with thirty Bangladeshi women in Tower Hamlets, East London, who have continuously used paan over a number of years. Participants were recruited through purposive sampling. Interview data was analysed thematically using grounded theory techniques (Glazer and Strauss, 1967) and then triangulated to compare and crosscheck the consistency of the research findings.

Findings: Key research findings indicate that while health discourses have explained paan use simply as a result of physical addiction to tobacco, exploring the biographical, historical and social context of paan use developed a deeper understanding of how the participants constituted the experience and meaning of paan addiction. Four key themes emerged - physical and psychological addiction, availability and social acceptance of paan chewing, lack of involvement in the wider social environment and 'Sylhetisation', (a

concept introduced by this thesis to describe how the Bangladeshi community have created an environment similar to that of Sylhet). The main recommendation is that an understanding of the sociocultural aspects of paan use may help greatly in developing more culturally specific paan cessation strategies within tobacco policies.

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AUTHOR'S DECLARATION

I declare that the work in this thesis was carried out in accordance with the Regulations of the Bath Spa University. The work is original except where indicated by special reference in the texts and no part of the thesis has been submitted for any other degree. Any views expressed in the thesis are those of the author and no way represent those of the Bath Spa University.

The thesis has not been presented to any other University for examination either in the United Kingdom or overseas.

Signed Date

…… ……..

DEDICATION

To my late parents whose life of compassion and tolerance taught me to overcome the hardships of life with creativity.

GLOSSARY

Bangladeshi	People of Bangladeshi origin
Banglalog	Bangla people
Bidesh	foreign
Bhuth	ghost
Eid	an annual Islamic festival marking the end of Ramadan
Gorelog	white people
Gua	areca nut
Gutka	pocket size tobacco products
Koran	Holy book of Islam
Londonis	people who have travelled from Sylhet to London, or their relations
Nani	grandmother
Paan	betel leaves or the mixture of the same with areca nut tobacco and slaked lime
Paan masala	same as above or pocket size paan products
Ramadan	A month of fasting, 9th month of the Islamic calendar
Supari	betel leaves
Sylheti	associated with Sylhet (people, language or commodities)
Zarda/ zada	tobacco powder/ tobacco leaf

CONTENTS

CHAPTER 1: INTRODUCTION

Introduction 1

Aims of the research 3

Current key issues associated with paan use 4

Paan products 7

Rationale for this approach 12

The research design 15

Outline of remaining chapters 16

CHAPTER 2: BACKGROUND TO THE STUDY

Introduction 19

Health and illness: explaining inequalities 21

Health inequalities 23

Ethnicity and Health 26

Gender inequalities in health 29

The role of paan in Asian culture 32

Healing qualities of areca nut and betel leaf 34

Cultural explanations and migrant health 35

Health and illness narrative and lay knowledge 39

Research related to paan use within the Bangladeshi population 43

Government interventions and public policy 47

Current provision for paan prevention: a medical point of view 50

Summary 54

CHAPTER 3 METHODOLOGY: THE NATURAL HISTORY OF MY RESEARCH

Introduction 56

Rationale for ethnography 59

Insider/outsider perspectives in doing ethnography 62

Ethical considerations 68

Phase 1: Fieldwork 71

Investigating key stakeholders 73

Meeting with Health Professionals 75

Meeting with local Bangladeshi people 77

Participant observation 78

Field work visits and observations 82

Focus groups 82

Phase two: In-depth interviews 86

Constructing a sampling strategy 86

In-depth interviews 90

Interview process 93

Data Analysis 95

Reflections: Methodological lessons learned 99

Conclusion 103

CHAPTER 4: TOWER HAMLETS, SYLHET AND BANGLADESHI WOMEN

Introduction 105

Tower Hamlets: Home for the Bangladeshi women 106

A brief history of racism and intolerance 108

Sylhet: The land of ‘Londonis’ 118

Sylhet migrants then and now 122

Bangladeshi women 127

Cultural dynamics of transition 130

Conclusion 134

CHAPTER 5: RESEARCH FINDINGS: EXPERIENCING PAAN ADDICTION/ DEPENDENCE

Introduction 136

Medical definitions of addiction 138

Neurobiological adaptation (first layer) 140

Manifestations of addiction (second layer) 145

i) Drug addiction and emotion: feeling different 146

ii) Preoccupation with behaviour 149

iii) Temporary satiation 153

iv) Loss of control 156

v) Negative consequences 160

Need for Paan cessation projects 166

Conclusion 170

CHAPTER 6: RESEARCH FINDINGS: EXPERIENCES OF CREATING HOME

Introduction 172

Nostalgic memories 175

Missing home 180

Getting used to marital life 181

Arriving in Britain/ Language problems 185

Hostilities and achievements 188

Paan was not a problem then/availability 191

'Sylhetisation'/creating home 194

Incorporating Sylhet features in Whitechapel 199

Caring role of women 200

Younger generation 204

Effects of sylhetisation 206

Lack of wider social involvement 209

Segregation and uncertainty 213

Change of attitudes 216

CHAPTER 7: CONCLUSION AND RECOMMENDATIONS

Introduction 222

To what extent were the aims of the research fulfilled 224

The main areas of agreement and difference between the respondents 226

Connections between findings and other research 228

The way forward 230

Integrating appropriate intervention programmes of paan cessation 231

Education and training for health professionals 232

Campaigns to raise awareness of the harm related to paan chewing 234

Reconsider national tobacco control policies to include all 234

the related issues

REFERENCES 239

APPENDICES - PHOTOGRAPHS 275

CHAPTER 1: INTRODUCTION

The thesis

This thesis studies the use of paan amongst older Bangladeshi women living in Tower Hamlets, East London. More specifically, this thesis investigates the women's use of paan through an exploration of their experiences to build a better understanding of the significance of paan in their lives, a habit that is associated with detrimental and serious effects to health. Paan, which is also known as 'betel quid', or referred to as smokeless tobacco in some literature, is a mixture of betel leaf (Piper betel), areca nut (Areca catechu), tobacco (Nicotiana tabacum) and slaked lime (calcium hydroxide: Ca (OH)2) with or without other spices added for flavour. It is reported that an estimated 200-400 million people worldwide chew paan for its euphoric effects (Gupta and Warnakulasuriya, 2002; see also IARC, 2004 & 2005), which is mainly due to the presence of two stimulants, tobacco and areca nut. The addictive and carcinogenic nature of both these substances is well established by research (WHO, 2004). Existing research related to Bangladeshi women's paan use (Croucher et al, 2002) clearly indicates the presence of tobacco addiction among Bangladeshi women who use paan regularly (see also: Croucher et al, 2009; 2013). However, research related to paan use among this population is sparse. This may be due to it being problematic in a relatively small population compared to many other health problems encountered in general practice, or due to the assumption that paan chewing is a minority cultural practice. The lack of attention means health and social care professionals are unlikely to have the experiences of identifying and

providing help for paan use. This can create inequalities in health as Bangladeshi women who are paan users, may not receive appropriate assistance or attention in order to address their paan dependence. The few existing programmes delivering help are limited to providing a short term pharmacotherapy such as Nicotine Replacement Therapy (NRT), which is an evidence based treatment option supported by medical research.

Medical research is important in that it provides important knowledge of the harms related to paan use, but it is also the case that medical discourse frames substance use in particular ways. Assumptions are often made about 'traditional' cultural practice, and addiction is often framed in terms of individual choice and there is a parallel to related construction of a South Asian diabetes risk (Hill, 2006) in that a combination of genetic, cultural and lifestyle factors are used to explain high rates of diabetes. Hence, there is a need to look beyond these explanations to examine the people's own understandings and the meanings they attach to everyday behaviours that are problematised by health discourse.

Ferreira and Lang (2006), in their anthropological study of diabetes experiences among the indigenous community, gained access to the lived world of the participants in order to move away from the purely medical model of diabetes; they examined the indigenous models and understandings of the problem. By understanding the health problem and the historical context of their life experiences from the people's perspective, the researchers were able to make their problems visible to the outside world and also made it possible for indigenous people themselves to invite collaborations with clinicians, social scientists and researchers in order to find solutions within

their cultural context. By adopting qualitative in-depth methods to explore the study participants' experiences, it was possible to identify how health and illness are situated within complex social, cultural and biographical frameworks. Similarly, as there is a concern for Bangladeshi women's paan/ tobacco use as highlighted by the existing research, they require appropriate interventions to cease their paan use in the long term for health reasons.

In order to provide appropriate interventions, it is crucial to understand how they make sense of their paan use, what meanings they attach to this regular habit of paan chewing, and finally, if their paan use is associated with wider social, personal and environmental issues that are specific to them. It is also useful to know about other paan users rather than making assumptions that paan is simply a traditional cultural practice that they brought with them when they came to London. Hence, the key questions posed in this research are:

1) How and why did Bangladeshi women begin using paan?
2) How did regular paan use become part of their everyday experience and addiction
3) What role does paan use play in their lives?

Aims of the research

The following are the broader aims of this research study:

- To examine and summarise research on paan use and its impacts on health.
- To explore women's own experience of addiction through their life experiences.

- To investigate constructions of tobacco risk as a medical problem that is located within individuals, or within certain cultures.

- To critically examine policy and public health strategies related to paan habit.

- To demonstrate how the study groups' biographical experience, social relations and ethnic and cultural identities provide crucial insights into the meaning of paan use, and that these are in many ways positive aspects of their creating their lives and households in a new setting.

- To examine how the women have engaged with the material constraints of marginalisation.

Current key issues associated with paan use

Chewing paan is a socially accepted, age old Asian habit that still continues among many groups of people in the Indian subcontinent and in the Pacific regions. Tobacco is the second major cause of mortality in the world resulting in the death of one in ten adults (WHO, 2005). Areca nut, which is also erroneously known as betel nut, due to its association with betel chewing, is the fourth most widely used addictive substance in the world. The excerpt below is the conclusion of a recent review of areca nut and tobacco use published by the World Health Organisation (WHO, 2012: 7).

> Betel nut chewing induces oral precancerous lesions that have a high propensity to progress. Betel nut itself has been classified as a group one carcinogen (carcinogenic to humans) by the International Agency for Cancer Research (IARC). While it is clear that the use of betel nut alone is a threat to health, its combination with tobacco greatly

> increases an individual's risk of premature illness and death. In countries in the Western Pacific Region where this is observed, betel nut and tobacco chewing has become a significant public health problem . . . . A major effort needs to be made to provide decision-makers with evidence of the serious harm caused by betel nut chewing, with and without tobacco. Community-based strategies are also needed to overcome cultural beliefs and practices that are barriers to sound public health measures that can save lives and prevent unnecessary suffering from oral cancer and other diseases.

Large population based studies of paan use in developing countries have been published over the last few decades by the WHO and scientific research communities across the world highlighting the health risks related to paan chewing (see Kiyingi, 1991; Bedi and Gilthorpe, 1995; Warnakulasuriya, 2002; WHO, 2005). It should be noted that there is a misunderstanding and confusion due to the terminology used in research literature when 'paan use' is defined as tobacco chewing. Paan is often chewed with tobacco and areca nut. Tobacco/paan chewing is associated with a range of diseases that are prevalent among Asian population, including oral disease and cancer, cardiovascular disease and diabetes (Millward and Karlsen, 2011: 4). The majority of the research (Ariyawardana et al, 2006) tends to focus on dental decay and cancer in the mouth, pharynx and esophagus, (see also Nigam and Srivastava, 1990; Bedi, 1996,) whereas, a lesser number of studies have highlighted the problems of dependence/addiction (Pau et al, 2003; Croucher et al, 2003a). As a result of this global scientific research evidence, the World Health Organisation (WHO, 2004; 2012) has branded chewing paan/betel

quid as harmful and injurious to health; paan consumption is now considered as a public health concern in countries where it is used (see also: WHO, 2003, 2003b, 2008, 2009 and 2010).

Chewing tobacco is highly addictive and studies have found that users have blood nicotine levels that are as high or higher still than cigarette smokers (Benowitz et al, 1990, 2010). However, while the health promotion against tobacco smoking is worldwide, the problems related to chewing paan have long been marginalised in global as well as national tobacco policies and up till now only very limited attempts have been made in terms of researching, raising awareness or prevention of paan related harm. As such there is a paucity of research on chewing paan, which is a social practice mostly prevalent among socially disadvantaged populations such as the study population of this research: the first generation of Bangladeshi women who migrated to England since the early part of the 1970s. It is probable that as the prevalence of chewing tobacco is relatively low compared to smoking and as it is viewed as a marginal sociocultural practice; health care professionals are unlikely to have extensive knowledge in the management of paan use in terms of health promotion and prevention. However, recent developments in the field of health have led to a renewed interest in smokeless tobacco use. This is mainly due to the dramatic increase in smokeless tobacco use in recent years. Tobacco products, including paan are now readily available in shops in South Asian neighbourhoods in England.

Paan products

Paan products are available in Asian grocery shops. These products are the takeaway type of paan mixtures which are very popular among men. They are industrially manufactured in India and Pakistan in large scale and distributed within these countries as well as exported to other countries in the Indian subcontinent. Furthermore, these products are exported to Western countries too. Different product types are sold without any regulatory health warning. Under the terms of the 2001 EU Tobacco Products Directive 2001/37/EC, smokeless tobacco products are required to have health warnings (Devlin et al, 2005). However, many of these products, which are readily available in local communities with large South Asian and Asian populations, fail to comply with the law (Longman et al, 2010). Longman's study on the accessibility of chewing tobacco products in England found that of the ninety four pre-packaged products purchased only 15% (2010:372) complied with legal health warning requirements. Generally, they are cheap compared to cigarettes.

Some of the products display confusing messages. For example, slaked lime does not display any health warning signs. Instead, it is labelled as 'not edible' although it is meant for oral consumption with other ingredients of paan. Before the industrially manufactured paan products came into the market, paan was only made of fresh ingredients. However, with the pressure mounted by health and welfare groups backed by the WHO, India banned tobacco advertising (Gupta and Ray, 2004). But, paan traders had to find an alternative way of promoting tobacco and they found an even easier option. They introduced pocket size paan products which became even more popular

due to the way they were formulated and packaged. This has made health professionals and researchers extremely concerned and they have also campaigned against the sale of these products.

As Gupta and Ray (2004: 57) have described:

> A major change in betel quid/ areca nut use occurred in India when an industrially manufactured mixture of areca nut, lime, a catachin-containing substance, sandalwood fragrance and tobacco was introduced to the market in small aluminium foil sachets. This product was termed Gutka and the same product without tobacco was named Paan Masala. Most companies manufacture Gutka as well as paan masala and market both products with the same brand name and packaging. This way manufacturers bypass restrictions on advertising of tobacco products on radio and television since there is no restriction on the advertisement of paan Masala … Cyclamates are added to sweeten the mixture and attractive flavouring agents like sandalwood, are included. Sachets are bright, colourful, often with blatant appealing brand names such as “Sir”-a common form of address from student to a teacher in India.

Since the appearance of ‘gutka’ in the markets, various brands of powdered paan mixtures have been on sale under various trade names. Paan products have attractive names and fruity flavours too. These paan products had similar packaging and marketing strategies (see McEwen, 2011). Some of them are sold as tobacco-flavoured toffees (see pictures of paan products in the Appendix). There is documented evidence to show that use of these paan

products causes mouth cancer and It has been recorded that India has the highest incidence of oral cancer in the world due to the use of paan products (see: Warnakulasuriya & Johnson, 1996; IARC, 2004,). While paan products are popular among the young people, chewing the fresh paan quid seems to be more popular among older women.

In England, the highest proportion of self reported chewing tobacco products is among Bangladeshi women (Sproston and Mindell, 2004). Furthermore, the existing research (Prabhu et al, 2001) suggests that, those from lower socioeconomic groups, those in older age groups and people from Bangladeshi origin are more likely to use smokeless tobacco. The meagre, but vital existing scientific research outcomes have identified paan addiction/ dependence among Bangladeshi women and emphasised the need to recognise and address the current public health concerns related to harmful effects of paan. This should especially be so in the current atmosphere of social and welfare reforms in which policy responses are wide ranging and there are initiatives to address the health inequalities in order to improve health outcomes and the use of health services by ethnic minorities in Britain (Marmot, 2004). However, Bangladeshi women's paan use remains under-researched and under-funded and given the health impacts outlined above this could certainly lead to inequalities in health. It has been widely suggested that there are inequalities in health with a higher proportion of people from the ethnic minorities and lower socio-economic groups reporting ill health (Whitehead, 1992). However, there are important points to raise about the

assumption that cultural difference is a causal factor in health inequalities as will be explored in chapter two.

Ahmad (1993) contends that there are two trends emerging through the existing research on health of minority groups. Firstly, there is racialisation of health issues which assumes that populations can be categorised in to racial groups for explanatory purposes; some racial groups are more vulnerable to certain diseases (such as the Asian diabetic risk). Secondly, ill health is attributed to the cultural differences and social practices related to them. As Reed (2003) argues, ethnicity and culture are important parts of a complex web of influences on health choices, which includes a range of influences from family to geographical location. Current research on paan addiction has paid limited attention to these influences that contributes to paan use among Bangladeshi women. As such there are inequalities of health in the way paan addiction is addressed in public health programmes. In addition, studies based on smokeless tobacco use of South Asians (Auluck et al, 2009) have highlighted the following challenges associated with developing interventions to stop using and potential barriers to helping people who use smokeless tobacco (see also, Health Development Agency 2000; Longman et al, 2010; Panesar et al, 2008; Roth et al, 2009).

- Health beliefs that tobacco products are healthy and therapeutic.

- Social acceptability and religious belief in the divine nature of the areca nut.

- Lack of services and materials in appropriate languages.

- Low level of awareness among health professionals.

- A lack of awareness of the tobacco content of these products.

- The belief that smokeless tobacco is part of some users' cultural identity and the upheaval of migration can create a particularly strong attachment to it.

While the aforementioned challenges indicate the need to examine paan use within a wider sociocultural context, as discussed earlier it is also important to examine the policy context under which, the regulation of paan products/ smokeless tobacco is addressed.

Tobacco policies play an integral role in influencing smokeless tobacco use as well as prevention strategies. This demonstrates the complexities associated with paan use that can lead to health inequalities among older vulnerable Bangladeshi women. By contextualising health choices and understanding the material and cultural circumstances as well as the biographical history of individuals, good qualitative research (Reed, 2003) can contribute to addressing inequalities in health. Although extensive research has been carried out about the carcinogenicity and addictive qualities of tobacco and areca nut, no single study has aimed to conduct an in-depth ethnographic exploration of paan use among Bangladeshi women, and this research aims to address the gap and complement the existing quantitative studies.
These findings and the recommendations of the study can impact upon the development and delivery of culturally appropriate education and prevention programmes for paan cessation. Furthermore, the data generated can also

be useful in enabling health professionals to understand the socio cultural complexities involved in paan use so that they can channel their help and support in a more appropriate and effective way.

Rationale for this approach

Central to this thesis is the notion that the practice of chewing paan among Bangladeshi women is a public health concern that needs to be recognised and addressed. However, over reliance on the neurobiological explanation of addiction/dependence and cultural explanations for paan use can obscure the impact of other factors influencing the continual use that is causing dependence. For example, issues related to social practice, social relations and social identity are important aspects of paan use. It is therefore necessary to understand the multiple dimensions of paan addiction within the context of other life processes. Thus, the three research questions raised at the beginning are; how and why did Bangladeshi women begin using paan, how did regular paan use become part of their everyday experience and addiction and what role does paan use play in their lives. In order to answer these questions this study employed a qualitative approach.

In the past, public health research programmes related to tobacco chewing have focused on questionnaire based surveys and short interviews to identify the extent of local knowledge about health concerns or to identify cultural barriers to health programmes. There are few problems in using such methods for paan use. First of all the pre-designed questions give limited opportunities for the participants to register their life experiences and concerns, instead they will have to agree or disagree with the provided

answers. It could be argued that the language used in questionnaires based research may not necessarily be the same that participants may like to use when giving their responses. Besides health practitioners, patients and social scientists all have their own culturally relevant strategies that determine if medicine is practiced in such a way as to effectively aid local health (Nichter, 2008). As such Nichter points out that a detailed understanding of folk epidemiology is crucial for constructing effective health plans. At a time when drug users were labelled as deviant, Becker's work with marijuana users (Becker, 1973) helped drug agencies to understand the reasons behind certain behaviours associated with drug use. This changed general attitudes, treatment options and service provisions in the United States and was followed by other countries too.

Qualitative research approaches seek to explain and analyse the culture and human behaviour from the point of view of those being studied. As Bryman (1992: 61) pointed out, the most fundamental characteristic of qualitative research is the express commitment to view events, actions, norms, values, etc. from the perspective of the people who are being studied; the present study needed to explore all these areas and the health behaviour and attitudes related to paan use.

Qualitative approaches to health behaviours have become significant for several reasons. They are useful for identifying local perceptions of health and health behaviours, and exploring such behaviours and related issues about which little is known. Furthermore, qualitative approaches are suitable in identifying relevant intervention strategies and target populations as well as

investigating the feasibility, acceptability and cultural appropriateness of potential new health programmes. In addition, they are also useful in evaluating existing interventions and suggesting more appropriate solutions, and developing relevant culturally competent education materials.

Currently, there is an increasing tendency to use qualitative approaches in research (Smith et al, 2003; Keval, 2009) related to health issues such as diabetes. A study based on health beliefs and folk models by Greenhalgh and colleagues (Greenhalgh et al, 1998) highlighted the importance of building health promotion programmes on the beliefs, attitudes, and behaviours already existing in Bangladeshi culture that promote disease control and address practical barriers to positive health behaviours. These broader dimensions cannot be quantified and need to be understood within a cultural and environmental context. When researching culturally specific phenomena, ethnography can be considered as the most appropriate approach (Fetterman, 1998; Hughes et al, 2002).

Qualitative methods are particularly useful when the subject of research is relatively unexplored and the research question is loosely defined or open-ended (Helman, 1991). There has not been any published ethnographic research based on Bangladeshi women's use of paan; it is an area yet to be explored and this research explored and described the local beliefs of the socio-cultural aspects and the meanings attached to paan chewing within this population sub group. This approach also helped to investigate the impact of current tobacco policies in terms of the trade and availability of the ingredients of paan and its products. The findings of this research will complement the existing knowledge of physiological effects of paan and contribute to the

understanding of the socio-cultural aspects and other determinants that influence paan use among the study population.

The research design

Hence, this study has employed ethnographic methods for data collection. The location of the research is the London Borough of Tower Hamlets (LBTH), where Bangladeshis account for 30% of the total population within the borough (ONS 2011). Being close to one third of the population of LBTH, the Bangladeshi population is visible in Tower Hamlets. There are many Bangladeshi shops and enterprises as well as community centres. Special programmes offering advice on health, education and other relevant services are provided by the local council. In addition, there are other immigrants from Asia, Africa and Eastern Europe living and working in Tower Hamlets. Hence, it is also culturally diverse and provides a rich source of information about the environment where Bangladeshi women have lived over the last three decades. The data collection was completed in two phases.

Phase 1: Following a systematic review of the literature, an extensive field work in the borough of Tower Hamlets was carried out over ten months. It was possible to be immersed in the environment of the study subjects. It gave excellent opportunities to meet other stakeholders relevant to this study, visit places of importance frequented by Bangladeshi women, such as hospitals, dental institutes, GP surgeries, community centres and mosques. In addition, there were opportunities to observe groups of Bangladeshi women participating in various activities organised by the local authority and the voluntary sector.

Phase 2: In the second phase, 30 Bangladeshi women aged over 50 years were interviewed. The selection procedure is explained in the Methodology section. As all the participants were able to speak and understand English, interviews were held in English on a 1:1 basis. Informed consent was obtained after explaining the aims of the study.

Interview data was recorded, transcribed and analysed using grounded theory techniques developed by Glaser and Strauss (1967). Grounded theory may be defined as the discovery of theory from data systematically obtained from social research (1967: 2). Emerging concepts were carefully categorised in order to understand the recurring themes as well as the statements that did not fit within the emerging themes. Data collected through different methods were compared and triangulated in order to confirm the credibility of the findings.

Outline of the remaining chapters

The thesis comprises a total seven chapters. The background to the study is presented in chapter two. It begins with a brief examination of other studies that highlight the importance of cultural beliefs and lifestyles in understanding health behaviours of people. The chapter examines current understanding related to health inequalities in terms of ethnicity, gender, migration history and biography. In addition this chapter will also discuss the related research to lay down the knowledge and cultural significance of paan. It will also review the research on tobacco use among Bangladeshi communities and current service provision for tobacco cessation. The chapter highlights the need to

comprehend health behaviours and understand the personal, environmental and social circumstances that influence people's actions towards health.

Chapter three provides the methodology; the natural history of this research. It begins by outlining the rationale for using ethnography, followed by a short discussion on the ethical considerations involved in researching a potentially vulnerable population. It further describes the, 'insider outsider perspectives' involved and the research process in detail. This includes the fieldwork, sampling strategy, recruitment of research participants, in-depth interviews and data analysis. The chapter concludes with the researcher's reflections.

Chapter four provides an overview of the present and past habitats of the study sample; a brief history of the London Borough of Tower Hamlets and Sylhet from where the study sample migrated, and an account of the Bangladeshi women themselves. It is necessary to understand the symbiotic relationship between people and location in order to place the subjects of the current study in their present context.

Chapter five and six comprise the full account and discussion of the findings. The women's narratives identified their relationship with paan as an addiction to the substance. Four themes emerged from the study as causes related to paan dependence; physical addiction, availability and social acceptance of paan use, Sylhetisation (creating Sylhet within Tower Hamlets) and a lack of wider social involvement, which leads to positive aspects of their social relations with other Bangla women and their partial marginalization in Tower Hamlets. Chapter five describes the current understanding of addiction in terms of addiction theories and the women's own descriptions of how and why they felt they are addicted to paan. There is a brief discussion of the

relevance of Nicotine Replacement Therapy; it is the only effective (Croucher, 2009) treatment option currently available for paan users.

While chapter five described the addiction in detail, chapter six discusses the way the other three factors have influenced their paan use. Paan use is tied into Bangladeshi women's biographical experience of difficulty and success, exclusion and the construction of home and place and making new social bonds. While it was not a practice that came with them, it is part of the past that they brought to England. The chapter also highlights the way in which Tower Hamlets has been transformed in to a small 'Sylhet' creating a home within their home. This has facilitated the availability of paan in large quantities at a reasonable cost. While paan is linked to the flourishing of their social bonds, it also confined them to smaller social groups that kept them away from the wider community. The chapter also highlighted the willingness of the participants to cease paan use altogether. Finally, in chapter seven the conclusions from the study and recommendations for future practice are suggested. In evaluating the aims and findings of this study, the conclusion chapter discusses the extent to which the findings are expected, a summary of the main areas of difference and agreement between the respondents, connections between the findings and other research in the literature review and the way forward in terms of recommendations for future practice.

CHAPTER 2: BACKGROUND TO THE STUDY

Introduction

The key aim of this study, as further expanded in chapter 1, is to explore paan chewing experiences of a small sample (30) of older Bangladeshi women from their perspectives. This is important for two main reasons: firstly, despite the research evidence that paan is injurious to health; the problematic paan use of this study population has been ignored by public health authorities for a very long time. The lack of attention given to this issue is perhaps due to this being a problem associated with a relatively small number of people, a minority among a minority population, or perhaps because it is viewed as a 'traditional' cultural practice. Secondly, in order to address the problematic paan use it is necessary to understand the sociocultural aspects underlying the paan habit. Understanding the above two areas is crucial in order to design and deliver effective and appropriate health promotion strategies and to inform the health professionals who are engaging with this group without a good understanding of how paan may affect the health and well being of their patients. There is evidence from recent research that improvements in service uptake and tobacco cessation rates among ethnic minority groups are likely to come from the development of culturally appropriate interventions (Netto et al, 2010). Therefore it is essential to recognise and understand the complexities surrounding paan use among Bangladeshi women and address the emerging public health concerns related to harmful effects of paan. This is especially so in the current atmosphere of social and welfare reforms in which there are initiatives such as Tackling health inequalities (Marmot, 2004; DOH, 2010), to

improve health outcomes and the use of health services by Black and Minority Ethnic groups (BME) in the UK.

Although paan is a socio cultural commodity within many South Asian communities, paan use is more prevalent among Bangladeshi women. According to the health survey for England 2004, the highest proportion of self-reported use of chewing tobacco products is among Bangladeshi women (Sproston and Mindell, 2004a). However, as mentioned earlier, there is a scarcity of in-depth exploration of paan use among this population. Existing studies have highlighted the higher prevalence of oral cancer and numerous other health problems related to the carcinogenicity (WHO, 2005; 2012) of the constituents of the betel quid and, and in the UK dependence/ addiction among populations who chew paan and its ingredients (Croucher et al, 2002). Existing research demonstrates the study population is at risk of developing health problems and addiction. However, there is no designated strategy within the national tobacco control policies to educate or promote health against paan use among this population; as such current service provision for paan cessation is sparse. On a local level, a few regions in the UK, including the London Borough of Tower Hamlets, have taken initiatives to offer some help in terms of Nicotine replacement Therapy (NRT) for those who use smokeless tobacco. While the serious health impacts of paan use have inevitably given rise to medical focus on the risks associated with using paan, it is important to be aware of how the medical approach frames paan use.

As yet, there has been no in depth qualitative research relating to paan use, or the factors that may influence paan addiction from the user's perspective. In order to address this gap, and develop understanding of the socio cultural

circumstances and the complexities surrounding paan use, it is necessary to examine the lived experience related to paan dependence among the study population. Firstly, it is important to understand factors that could shape the health and well-being of this group, and look at debates concerning the causes of health inequalities that affect the study sample. Secondly, it is crucial to examine the sociocultural factors and tobacco policies that may affect paan use and prevention of paan dependence. Hence, this chapter will commence with a brief examination of the health inequalities that may affect the health of the study population as highlighted by published government reports and other research literature. In order to frame the study within a broader social context, it will briefly examine the notion of socioeconomic determinants of health in terms of materialist and psycho-social environment explanations. Health inequalities are discussed in terms of class, ethnicity, gender. It is appropriate to note that paan use is interesting because it is an everyday behaviour rooted in a socially specific setting that has come to be seen as a medical problem. However, there is also a danger in labelling and ignoring paan use as a cultural habit that came about as a result of a symbolic or nostalgic act in the process of settling down in a new country. Therefore, this chapter will also examine issues related to the way migrant communities make sense of their health, the social role of paan and the tobacco policies that may have an indirect effect on paan use among the Bangladeshi women.

Health and illness: explaining inequalities

Health and illness can be considered as similar to the two sides of a coin. There appears to be a great diversity regarding definitions of health; lay

definitions or interpretations of health are more diverse still, as they represent personal experiences of health and illness (Reed, 2003: 28). However, health is shaped by many different factors such as lifestyle, material wealth education attainment, job security, housing conditions, psycho-social stress, discrimination and the health services (Marmot, 2005). Health does not mean a complete absence of illness; neither can illness be interpreted as an absence of health. The terms health and illness refer to a wide spectrum of body states, which is caused by a variety of bio-psychosocial interactions with the human body and mind. As research has mapped the incidence of ill health and disease in society, patterns have emerged which require explanation. As this section will go on to discuss, the difficulty is developing a clear understanding of the causes and consequences of these patterns. As Lambert and Sevak (1996), pointed out the epidemiological studies seemed to have focused on causal links between illness and racial groups; an example is the increased incidence of health conditions such as diabetes within certain populations under study. Where difference has been linked to ill health, assumptions have been made about how difference might cause ill health. Moreover these studies are based on quantitative data and biomedical models of health and illness. As Reed (2003), indicates, the limitations in such health research is the over reliance on epidemiological studies on explaining the association of health problems cultural differences rather than health inequalities. Besides, such studies are not able to explore the experiences of the way in which people make health choices. Hence, it is imperative to look beyond simplistic models of how difference might be related to health issues in order to consider the holistic picture of health and illness.

It is now widely accepted that ethnicity, gender, social class, environmental factors, and genetic constitution are major determinants of health and wellbeing. As Baum (2002) emphasised, explanations for health inequalities are multifaceted and, are seen as a result of everyday lives of individuals. Furthermore, in the current globalised environments in which the societies live, immigrant populations such as Bangladeshi women in this study can undergo, as Nazroo (2001) contends, a great deal of stress and social disruption as a result of moving to an unknown, unfamiliar and potentially hostile environment. Hence, there is a need to understand the way such circumstances affect health choices individuals make, such as paan use among Bangladeshi women that can lead to health inequalities.

Health inequalities

There has been a vast amount of literature highlighting the existence of a social gradient in health (Marmot, 2005). The existence of inequalities in the health experience of different ethnic groups, class and gender in Britain is now well established (Sproston and Mindell, 2006). Health inequalities occur due to multiple reasons. Even in early studies it was clear that one of the key issues that needed explanation was the class gradient in health. There have been a number of investigations related to the health of the nation including the Black Report (1980), the Health Divide (Whitehead, 1992) and the Acheson Report (1998) revealing the nature, scale and the causes of inequalities of health in the UK. The remit of the Black Report was to investigate the problems of inequalities in health in the UK and analyse health records of people from all social classes.

The Black report (1980) found that the health improvement had been unequal across all social classes and there is a widening gap in inequalities of health between lower and higher social classes. It investigated possible causal explanations of the class based differences, and argued that ill health was mainly due to social and economic circumstances such as unemployment, poor housing, poor social environment, income and education (Baggott, 2000). The recommendations it put forward, focused on two main areas namely, reducing poverty and spending more money on health education and the prevention of illness.

There were several controversies regarding the report. It should be noted that in all the reports prior to 2001, the social class was categorised according to Registrar General's Classification which is mainly based on the nature of the employment. The limitation here is that the unemployed people and specific groups such as housewives, children, retired people and those who have been sick for a long time cannot be assigned to a social class within this classification. Rectifying this problem, in 2001 the Office for National Statistics replaced the Registrar General's Classification by the National Statistics Socio-economic Classification (Baggott, 2000). Although it was also based on occupation, there was provision for the acknowledgement of the whole adult population within this classification. This includes those who are unemployed as well as self employed, both of which are relevant categories for ethnic minority groups such as Bangladeshi population.

Based on the findings of the Fourth National Survey of Ethnic Minorities, by using the National Statistics Socio-economic Classification (NS-SEC), Chandola (2001) explained that there was lack of evidence for class

difference in health among the Pakistani and Bangladeshi populations., indicating that class, material disadvantage and ethnicity were not straightforwardly related. Furthermore, the findings indicated that there was some evidence for the existence of class differences in the health of people of Indian origin. Although associations between socio economic inequalities and health inequalities are apparent, there are other recent studies (Gravelle and Sutton, 2009) that did not report a highly significant relationship between socio-economic inequalities and health inequalities.

When the Black report was published it was heavily contested by the new Conservative government, which took an individualist approach stating that it is the individual behaviour that shaped health (Baggott, 2000). This controversy led to the next report, The Health Divide (1987), which is also known as the Whitehead Report, was commissioned by the Health Education Council in order to assess the progress made since the Black Report and update the evidence on inequalities in health. This report restated the findings of the Black Report and also revealed that since the publication of the Black Report the gap between the social class and health standards had widened. Again, there was controversy about government acceptance of the findings of the Whitehead Report. While the Health Education Council was campaigning against alcohol and tobacco, the very industries were funding the Conservative party. Eventually the Health Education Council (HEC) was abolished by the government (Baggott, 2000).

Following the abolishment of the HEC, the next investigation in to health inequalities in the UK, the Acheson Inquiry was commissioned by the new labour government in 1997. It was a comprehensive survey of the

disadvantaged groups of people, findings of which mirrored those of the Black Report. The Acheson Report (1998a) identified poverty as the root cause of inequality and emphasised the importance of reducing the gap between the richest and the poorest. Furthermore, it recognised that there was a relationship between socioeconomic status and health for some migrant groups. Meanwhile, a study of immigrant mortality by Marmot et al (1984) concluded that class and the material explanations did not straightforwardly explain poor health and mortality rates among the ethnic minorities. This debate is even more complex and contested in relation to health inequalities associated with minority groups. Using data from the Fourth National Survey of Ethnic Minorities, Nazroo (1997) pointed out that there was a need to consider other elements of the structural disadvantage faced by ethnic minority groups, such as their experiences of racism or concentration in particular geographical locations. Hence, social class on its own is not adequate in explaining ethnic differences related to health. Inequalities of health exist between different genders, different ethnic groups and the elderly and people suffering from mental health problems or physical and learning disabilities.

Ethnicity and health

Globally there has been a wealth of evidence showing the inequalities of health among ethnic minorities, (Wilkinson and Pickett, 2009). For example (Marmot, 2005) pointed out that while Australian life expectancy is among the highest in the world, there is a life expectancy inequality gap between indigenous and non-indigenous people. This difference has been attributed to

the increased mortality from non-communicable diseases such as smoking, alcoholism, obesity and poor diet (WHO, 2003b). In England there have been a number of studies highlighting the higher rates of morbidity due to poor health conditions such as diabetes and heart disease among South Asian population (Nazroo, 2001). Examining health inequalities of minority groups may be very complex in relation to material/cultural difference. Comparisons of minority ethnic communities with the majority community 'norm' in terms of morbidity, mortality or health related behaviour, including use of services, have been a common form of research which tends to find excess morbidity, mortality, or deleterious health behaviour among the minority in question (Ahmed and Bradby, 2007: 803). The authors further emphasised that ethnic minority health need not be considered as a comparative problem; instead it needs to be considered as a significant condition on its own right. If not, health problems can be easily be ignored when seen and understood as a cultural issue.

While the research related to the broader contextual factors that contribute to various health conditions is limited, it is crucial to understand the wider social issues that can affect the health of ethnic populations. A systematic review relating to smokeless tobacco use among South Asian users in England (Messina et al, 2013) found that contextual factors such as stress, boredom, traditional health messages and health beliefs and lack of awareness of the health risks may lead to chewing tobacco; the review further emphasised the desire to quit, but the inability to abstain from chewing tobacco, a feature which is associated with psychoactive substance use. These findings echo the outcomes of other tobacco studies (Kakde, 2012) and to some extent with

the findings of the present study. Findings of the Messina et al (2013) research are based on extractions from studies selected using an iterative search strategy in targeted databases and grey literature sources, all of which tend to be quantitative in nature. Nevertheless the review is valuable in that it examines and establishes not only the relationship between ethnicity and complex factors that underpin and influence smokeless tobacco, but also the complexities related to the aspects of addiction including socioeconomic factors. There is a tendency to over-simplify the link between cultural influences on lifestyle as a causal factor, this is an issue explored in more detail later in this chapter.

When examining paan use and socioeconomic status, the prevalence of chewing tobacco varies by level of deprivation. It has been highlighted in the majority of studies that paan users seem to be from less educated and less privileged sections of society (Gupta and Ray, 2004). In Bangladesh, lower socio-economic groups and educationally deprived people were more vulnerable to betel chewing, because it is a cheaper pleasure, affordable by the least advantaged members of the community (Flora et al, 2012); this study further reported that improving the socio-economic status of people, decreased the prevalence of the habit. Hence, it is important to note that material factors are very likely to have played a role in shaping Bangladeshi women's paan use. However, there is also a need to examine the issues related to gender inequalities in health.

Gender inequalities in health

Both biological sex and social gender have implications for health. For example during the reproductive years women are protected by sex hormones thereby reducing risks of illnesses such as coronary heart disease. While women are vulnerable to breast cancer, men are susceptible to prostate disease. However, social factors can interact with human physiology overcoming and overruling the biological influences in both men and women to produce socially constructed patterns of morbidity and mortality at different times and in different parts of the world. In general women tend to live longer than men, however, this longevity fluctuates, across societies depending on the socioeconomic situations and other forms of discriminations. Women's experiences differ by race, class, geography,and economic status as well as by the variety of their individual histories (Doyal,1995). Although not all gender roles and differences imply inequity, they can give rise to gender inequalities in health. Therefore it is important to acknowledge the existence of gender biases within the societies. However in post colonial research, as Phillipson et al (2003) point out, although the studies of migration, colonisation and class have formed an important context for understanding ethnicity, they have also frequently understated gender.

In the past women were seldom included in studies of health inequalities. As such there existed a paucity of large scale epidemiological studies of health inequalities among women. The reasons given for the justification are the lack of data and a belief that health inequalities are a smaller problem for women than men (Vagero, 2000). It has also been highlighted that it is more difficult and controversial to classify women by social class or by general standing in

the community (Sacker et al, 2000). As such there has been an omission of women from large scale epidemiological studies; for example research on health problems such as heart disease and cancer are predominantly based on men as study participants (Doyal, 1995). However, over the past few decades feminist writing has investigated and highlighted the gender relations associated with gender roles such as caring for the sick, nursing and , mothering, (Reed, 2003: 6). Feminist writers of South Asian origin (Puwar, 2003; Brah, 2007) have investigated gender roles and identities related to Asian women in the diaspora. They offered alternative accounts of South Asian women's embodiment, challenging current ways of thinking racialized and gendered bodies-the image of passivity that has so often been ascribed to Asian women. Nevertheless as Reed points out, there are only a small number of studies that have focused on health choices of ethnic minority women.

Reed's study with Asian mothers, whom she described as women with local and global connections, explored the ways in which, ethnicity, gender, generation and globalisation affected the health choices of the women involved. Based on her findings she contends that health choices necessarily have to be viewed in terms of context and syncrecy. Read (2003: 15) argues that health choices necessarily have to be viewed as 'processual' and change according to context (ethnicity/ culture, religion, class, access to health services, work and location in the family). The material position of women can certainly be an important factor shaping their health choices. For example, Leipert and Reutter (2005) used in-depth interviews to elicit information on how women in geographically isolated settings in Northern Canada maintain

their health. From their findings, they were able to demonstrate that the main problem for their participants was vulnerability to health risks, which is the result of their marginalisation. This is even more important when considering health of migrant women such as Bangladeshi women because cultural explanations often mask the effects of social inequalities on immigrant health outcomes. As Viruell-Fuentes et al (2012) point out a richer understanding of immigrant health patterns requires a shift in focus from individual level cultural explanations to research that provides a broader, more in-depth analysis of racism as a structural factor that intersects with other dimensions of inequality, such as gender and class, to impact immigrant health outcomes. Therefore, it is necessary to address interaction between all facets of diversity and discrimination that may be relevant to health inequalities rather than prioritising one such as class or ethnicity. By addressing questions of culture, identity and politics, feminist writers (Puwar, 2003; Ahmed, 2005; Brah, 2007) have examined these themes through the experiences of South Asian women as part of the diaspora, by exploring the intersections of `race', gender, class, sexuality, ethnicity, generation and nationalism in different discourses, practices and political contexts and highlighted the importance of intersectionality in health research. For example Ahmad (2003: 43) has raised the issue that historical and contemporary encounters continue to embody South Asian Muslim women through cultural and religious frameworks as essentially oppressed figures of victimhood and despair, but also as sexualised and fetishized ‘Others’. Furthermore, gender disparities in material position, education and status, relate not just to wider society but to their role in the home. For example, in her study with Bangladeshi women, Khanum

(1994: 289) notes that women's own image as self depriving and submissive led them to endure physical stress as well as psychological stress and to depend upon the household head's decision regarding their illness and treatment. This is important in terms of how culturally accepted views and opinions may influence paan use and prevention. As Kakde et al (2012) points out, vital factors such as family, friends and media act both as facilitators to continued use and barriers to cessation; therefore users with the desire to quit paan require a supportive and encouraging environment. It is therefore necessary to develop a holistic view of paan use; in order to achieve this it essential to understand the social and familial domestic context of consumption.

The role of paan in Asian culture

Paan is an integral part of Asian traditions. It has a very special role in all social activities from birth to death. The social role of paan is interwoven with religion and culture. Chewing paan dates back to the pre Vedic Saivite Harappaan Empire (Vasu, 1999). In addition to chewing, Paan had a significant place in other areas of life. Its health benefits, as well as its religious and cultural significance are documented in Indian, Chinese and several other Asian scriptures; it is therefore important to examine the social role of paan in order to understand socio cultural influences on paan use. Based on archaeological evidence in caves and in human remains (Gorman, 1969) the practice of chewing areca nut can be traced back to at least 2000 years in India and appears to have been much older in other areas (Asotra and Sharan, 2008). In ancient Indian culture, traditions and rituals were

distinctively associated with religion. Rituals are a significant part of Hinduism. It is customary to chant hymns, mantras and stanzas by officiating priests or representatives in religious activities involving not only births, marriages and deaths but also in activities such as house warming events, age attending ceremonies and an unlimited number of other special and mundane activities. Not only during these ceremonies and auspicious tasks but also in any situation where the priests officiate, natural items such as plants, animals, incense and fire had important roles. Areca nut and betel leaf have been among the plant products associated with these religious rites. For example in wedding ceremonies, prior to the fire circling stage, the garments from the bride and groom are tied together and a whole supari (areca nut) is encapsulated in the knot. `Since Bagwan (God) is an entire entity, the supari is used as a whole and not in its fragmented form (Williams et al, 2002: 153). However, there is no documented evidence related to paan in Islam religion, although substances that can confuse the mind is “haram” meaning prohibited (personal communications with faith leaders). It is believed that the paan tradition results from Hindu influence on Bangladeshi culture, because the inheritance of Indian culture is visible among non-Hindu populations in Asia. However, it should be noted that although religious connotations attached to paan are based in Hinduism, paan use is more prevalent among Bangladeshi women who are predominantly Muslim. This seems to be attributed to health beliefs associated with the healing qualities of betel leaf and areca nut.

Healing qualities of areca nut and betel leaf

Ancient Ayurvedic (Indian traditional medicine) books describe areca nut as a therapeutic agent. Extracts of the areca nut have been used for the management of glaucoma in traditional medicine (Morton, 1977). A complex system of reasoning for use of areca nut and betel quid are provided by the Sanskrit corpus of Ayurvedic and other works such as Charaka samhita, Susruta samhita and Asthang hardaya samhita (Strickland, 2002); these three books are considered as the great three classics of Ayurvedic medicine. An anti-depressant effect of the areca nut has been researched and it has been reported some of the alkaloids found in areca nut may relieve symptoms associated with schizophrenia (Sullivan et al, 2000). Ground areca nut is used in tooth powder in countries in the Indian Sub-Continent. It has been recorded that there were tooth paste containing areca nut in England in the 16th century (Schullian, 1984). Betel nut based medicines are used in removal of intestinal parasites in humans as well as in animals. Although currently it is not used in tooth paste, areca nut continues to be a topic of discussion among the health professionals. These medicinal values are known to Bangladeshi women who use areca nut and betel leaves for healing purposes. For example, they use betel leaves to stimulate lactation after child birth. Daubed with oil, leaves are placed on breasts and gently massaged to stimulate secretion of milk. Betel leaf is well known for its healing ability (see Rai et al, 2011) and herbal pastes and extracts are still used in the absence of modern medicine in rural parts of Bangladesh, India, Sri Lanka and Pakistan. These healing properties can be attributed to the chemical nature of the paan leaf and areca nut. Some of the active chemicals in the areca nut are used in

the pharmacological treatment in the industrialised countries. Bangladeshi women are familiar with its analgesic quality and use it as a self-medication for toothache. However, areca nut is often used with tobacco in the paan quid and this can lead to oral disease. Being aware of cultural beliefs can be helpful when designing health promotional strategies. Hence understanding this general cultural background can help health professionals in understanding the broader socio cultural context and the meanings attached to paan use, which can be useful when designing health promotional materials for paan prevention. The work of Greenhalgh and colleagues (1998) highlighting the importance of building health promotion programmes on the beliefs, attitudes, and behaviours already existing in Bangladeshi culture that promote disease control and address practical barriers to positive health behaviours has been already discussed in the previous chapter.

Cultural explanations and migrant health

Given the section above it might be easy to assume that paan use is simply a cultural tradition that has travelled with migrants in their journey to Britain. However, migrants constitute a very diverse group with different cultural and socio-economic backgrounds. When migrants move within countries or between countries, the majority of them carry their culture and traditions with them; however it should be noted that this cultural influence is as diverse as their origins. In addition, culture and ethnicity are not static. Researchers (Ahmad, 1993; Bhopal, 2007) have consistently critiqued the notion of culture and ethnicity as static and unchanging phenomena. It varies across time and place being influenced by multiple factors related to the environment such as

other co-existing cultures. It is also affected by social class, education and gender. Because of the patterns of health related inequalities discussed above, cultural difference has been the focus of much research. However, problems can arise when, as happens in many epidemiological studies, ethnic variation in ill-health is often seemed to be associated with an over-simplified conceptualisation of cultural difference between communities and assumptions about the way culture may influence health behaviours.

The phrase 'culturally appropriate interventions' has often been used in recommendations of research related to minority groups. This proposes the importance of certain specificities that need to be taken in to account when working with minority groups; health beliefs, value systems, language, religion and several other areas. However, this notion implies that individual health behaviours are straightforwardly influenced by culture and that this will have an impact on the health of a whole group. This has been highly debated by social researchers (Kelleher and Islam, 1996; Keval, 2009). For example Kelleher and Islam's (1996) study with Bangladeshi people highlighted the complex nature of the health choices people make when choosing treatment for diabetes; they found that people used both Western and other complementary remedies when managing diabetes on a daily basis; other researchers have reported similar findings. In the current study health choices varied even within the individuals of the same group thereby indicating the diversity and dynamism of the term culture; while paan use is seen as a cultural practice, not all Bangladeshi women are habitual users of paan.

Ahmed and Bradby (2007: 804) argues that the culture of special initiatives in the National Health Service was located in the crude multiculturalism of the 1970s, which stripped minority cultures of their complexity, contingency and dynamism and presented them as static, homogenous artifacts, whereby all members of a culture were assumed to share common features. The use of static definitions of culture in public health research risks homogenising ethnic groups and perpetuating racial/ethnic stereotypes (Hunt et al, 2004). Furthermore, it can inadvertently promote victim/ blaming explanations (Viruell-Fuentes, 2011: 38). An example is the way in which South Asian people in Britain are often perceived as a homogenous group whose culture is constraining, fixed and prescriptive; the epidemiology of South Asian diabetes is interpreted in terms of ethnicity and culture (Hill, 2006). As Keval (2009:257) argues:

The often vaguely conceptualised role of culture can again propose problems for South Asian groups by marking generalised claims that South Asian diets are lacking in fruit and vegetables, and that lifestyles are lacking in physical exercise…….. health science discourse has constructed what can be termed a *South Asian diabetes risk,* a discursive and practical mechanism through which a particular risk identity is shaped, using ethnicity and culture as fixed and static entities.

As the above quote indicates stereotypical representations obscure and misleads the need to understand practice in context. While the pattern of paan use being associated with older Bangladeshi women has been clearly established, there is little understanding of why this pattern of practice exists. Recently there has been some interest in qualitative research investigating

Bangladeshi male smokers. Highet et al (2011) studied the smoking behaviour of Bangladeshi men in terms of how they think of their smoking habit and cessation. The study found that family homes continued to be the key space where tobacco is consumed. Highet et al (2011) emphasised the importance of supplementing tobacco control interventions with culturally sensitive measures in local areas where there is a high concentration of Bangladeshi people. This demonstrates the need for such better designed, appropriately focused research on paan use and health interventions. Thus, while culture may play an important role in shaping migrants health, nothing should be assumed about the way cultural ideas and practices shape lives. Instead, it is necessary to understand the way other individual circumstances and social inequalities interact with issues related to immigration.

Ethnic minorities are often disadvantaged in terms of economic success, as well as being excluded from everyday mainstream society (Nazroo, 2001). This can shape their experiences of wellbeing and health behaviours over time. Higginbottom's (2006) study which explored hypertension amongst African Caribbean people residing in England, sought to provide a comprehensive and multi-faceted explanation for the experiences of the participants, and one that takes account of and recognises structural factors in addition to personal factors, including factors such as the cultural congruence of services and past incidences of racism. Her study (2006: 585) highlighted that variations in health and ill-health experiences between and within ethnic groups are not simply determined by culture and ethnicity (Karlsen and Nazroo, 2002a and b), but arise from the coalescence of complex factors

such as migration, cultural adaptation, racism, reception by the host community, socio-economic influences and prevailing societal ideologies. Embedded in these complex factors are people's health beliefs shaped by their life experiences. Hence listening to people's life experiences can give a better understanding of their health and illness.

Health and illness narrative and lay knowledge

In the face of ill health people develop their own accounts or stories which frame the experience in ways significant for them, this has been termed 'the illness narratives' of their condition Kleinman (1988) advocated the approach of listening to these narratives and interpreting the experience as a way of understanding the multi layered nature of illness. As Kleinman (1988:32) suggests, narratives are more than a reporting of illness, but are efforts to integrate or reintegrate individuals in to their social world. For example, at a time when evidence-based practice was the accepted medical view among the medical practitioners the patients' view of their condition was often not taken in to account when treating illness, however, listening to illness narrative can give a better understanding of the meanings attached to the symptoms. Hence understanding the narrative context of illness provides a framework for approaching a health problem holistically (Greenhalgh and Hurwitz, 1999). Also it can make it possible to communicate more effectively with the patient. Furthermore, those interested in exploring illness narratives in order to understand the meanings can influence policy and practice in terms of delivering better holistic treatment options.

Illness narratives are based on people's lay knowledge (Williams and Popay, 1994), a concept further developed from the idea of lay belief; it can be understood as ideas and perspectives employed by people in order to interpret their experiences of health and illness in everyday life. The key feature of lay knowledge is that it is holistic, drawing together scientific knowledge or other professional knowledge (Williams, 1993); while this knowledge is socially constructed, it is influenced by cultural values and ideologies of the times. Hence, it is not fixed; in the current atmosphere in which electronic information is widely accessible and diverse lay knowledge seems to be even more complex and wide. Managing health problems in the modern day can be more appropriately facilitated by better understanding of the lay knowledge related to health and illness; this can enhance better patient participation thereby reducing the sense of medicalisation of health and illness. Hence narrative approaches can give a better understanding of issues related to health and inform policy. Narratives not only give access to culture but how individuals perceive cultural changes over time – crucial in relation to health issues and experience of the body in a changing cultural context.

An investigation by Dyck (2006) with South Asian migrant women living in British Columbia, Canada, examined how traditional medicine and indigenous medicine, as subjugated knowledges, were in tension or integrated with western medicine in the women's approaches to keeping healthy and managing illness. The study explored how everyday spaces and experiences of migration — as women work, raise children, make friends and manage family life — may be implicated in the ongoing constitution and transformation

of knowledge of health and illness management. Analysis of the accounts shows intricate relationships among the body, food, place and identity. The study argued that these relationships are integral to the ongoing constitution of subjectivities and place in the context of the rapidly growing urban centres of the study. This demonstrates the dynamic nature of integrating different knowledges into practice, what is 'healthy' is a crucial aspect of self care and the care of others – yet this is contingent, subject to change and revision in new contexts. Based on the findings the study highlighted how qualitative approaches and analysis of health and illness 'talk' can de-medicalise immigrants' health behaviour, instead placing it within wider issues of integration and inclusion confronting racialized immigrant groups. Life course and biographical research can shed light on issues related to health and illness beyond the organic symptoms. Graham et al (2010) argue that in order to understand smoking behaviour it is necessary not only to examine current social status but at the life course of people and the way discrimination has effects that shape choices and outcomes later in life. Biographical experience of migration and discrimination shape people's lay knowledge about health practices. Through gendered narratives Dyck and Dossa (2007) explored the routine practices of South Asian women, whereby they work to create 'healthy space' as they orchestrate their families' health. The study highlighted that for the migrant women in their sample, access to social and material resources, including housing, work and social networks, frames the specificity of their health practices. Furthermore, the study emphasised that to be healthy involves not only the physical body, but also the ability to participate in Canadian society as an 'appropriate' cultural body.

The Illness narrative can explore lay knowledge on food and plants, which make a significant contribution to the way women make sense of their health. Employing a narrative ethnographic method Jennings et al (2014) explored the nature of food and plants and their meanings in a British Bengali urban context. It focused on the nature of plants and food in terms of their role in home making, transnational connections, generational change and concepts of health. The study highlighted that food is ultimately the embodiment of multiple and fluid meanings-home here, home there, parents, children, local communities, global communities and health and this embodiment needs to be taken into account in such dialogues aimed at groups like the Bengali community in Britain. This research further emphasised the need for greater dialogue between health professionals and those they interact with, to allow for an enhanced appreciation of the dynamic nature of food and plants and the diverse perceptions of the role that they play in promoting health. Research findings have demonstrated how narratives can be used to explore the multi-faceted material and cultural influences that frame the experience and meaning of behaviours. However, this approach has not been used in paan research. Hence it is a more suitable approach that can be used in order to understand paan use not as a fixed cultural phenomenon, but as an individual choice shaped through users' lay beliefs and knowledge influenced by many personal, social and environmental circumstances. Women's narratives can inform a more holistic view of their paan use and the health inequalities associated with it.

Research related to paan use within the Bangladeshi population

Smokeless tobacco is an addiction for millions of people worldwide (WHO 2008, 2009) and research indicates increasing use by young individuals in many countries (IARC, 2007). Research on chewing paan among Bangladeshi people in the UK has been sparse and sporadic; in the past few decades only a few researchers (see Bedi 1996, Croucher et al, 2002, Warnakulasuriya, 2002,) have published reports on this topic. However, it should be noted that research on paan use among women are minimal and the foci of the existing few studies are dependence, dental hygiene and the efficacy of the treatment which is substitution therapy, NRT. There is interest in whether Women's paan use can influence children to chew paan at a younger age; and how availability and social acceptance can encourage early use of paan.

An investigation (Farrand et al, 2001) conducted in two secondary schools in the London Borough of Tower Hamlets, where the Bangladeshi population is predominant amongst ethnic minorities, concluded that South Asian children may already be experienced users of areca nut and hence greater attention should be directed towards identifying oral sub-mucus fibrosis, oral cancer and other potentially malignant lesions within the South Asian population. This stresses the importance of early detection, another example of evidence-based medical opinion for intervention. However, some studies with young people indicate a decrease in paan use among the second generation. An investigation (Prabhu et al, 2001) based in East London to ascertain the level and predictors of betel quid (paan) chewing among Bangladeshi adolescents, concluded that the prevalence of paan chewing was lower than that found

among adults reported in earlier studies in the UK. The authors suggested that the reduction of paan chewing could be attributed to acculturation. On the contrary there are other researchers who have reported that chewing tobacco is increasing among teenagers and children due to the easy availability of paan products (Longman et al, 2010). These assertions raise two concerns; one related to the concept of acculturation and the other concerning methodologies.

Questions have been raised about the limitations of the concept of acculturation used in health research. The term acculturation is generally understood as a process of change that occurs when people of different cultural groups interact and share common geographical space following migration or relocation. The changes may take place as a result of adoption of all or parts of the host's or other's culture. The debate about acculturation has gained prominence with many arguing that the existing accounts of acculturation seem to fail to acknowledge the socio-historical context of migration when examining immigrant health outcomes (Miranda et al 2010, Viruell-Fuentes, 2011). As pointed out by Zambrana and Carter-Pokras (2010: 21).

The persistent use of individual or culture-driven models in public health ignores the effect of residence in low-resource communities, low SEP [socioeconomic position], the social construction of marked cultural identities, and institutional patterns of unequal treatment, all of which contribute to health disparities. Similar to the use of the term culture in health discourse, it has been highlighted that, in efforts to objectively model cultural influence on health, ethnic culture is commonly operationalised as level of ‘‘acculturation’’,

which is measured using acculturation scales designed to quantify the extent to which individuals embrace ‘‘mainstream” versus ethnic culture (Hunt et al, 2004: 974). Therefore giving up harmful health behaviour or adopting healthy lifestyles cannot be simply attributed to what is termed acculturation.

Methodologies used in paan research are dominated by quantitative research approaches. The conclusions are derived from data acquired by questionnaire-based interviews; therefore the terminology used for paan use becomes an important issue. Paan quid and paan products are two different categories. When paan quid is chewed with fresh ingredients, it becomes visible with red stains whereas the paan products on their own do not produce an immediate colouring effect in the mouth. This makes ‘pocket size’ paan products more attractive to young people who may not possibly count them as paan or tobacco. Hence, it is difficult to determine whether the prevalence of tobacco chewing accounts for the paan quid, paan products or for both. Inappropriate methodologies can lead to misinterpretations by the participants as well as by the researchers. An investigation in to self -reporting in research among Bangladeshi women found that there was under reporting of personal tobacco use (Roth et al, 2009). This has been echoed in the findings from the Health Surveys for England 2004 and 2008. On the contrary, Sproston and Mindell (2004) showed that when respondents with a saliva cotinine level indicative of personal tobacco use were also included, the estimates rose to an increased level. However, while there are controversies surrounding prevalence of paan chewing, all published literature on the ingredients of paan (areca nut and tobacco) has highlighted paan addiction among Bangladeshi population.

An investigation by Nunez de la Mora and colleagues (2007) evaluated the effects of socio- economic variables and migration history on the prevalence of areca nut and smokeless tobacco use in both UK and Bangladesh-born migrant women resident in London. They concluded that:

a) Although there are some indicators of change in the behaviour among younger individuals, areca nut chewing is a practice very much present among Bangladeshi women born and brought up in a bicultural context.

b) Betel nut use is addictive, with or without tobacco, and is widespread in all generations of the Bangladeshi community.

These conclusions mirrored the findings of other similar studies. For example an investigation by Croucher et al (2002) found that almost 50% of Bangladeshi women in Tower Hamlets chewed paan with tobacco and they were also found to be dependent on tobacco. As mentioned above, the arguments in these studies are unanimous in indicating that paan is associated with health risks including dependence and that there is a need for intervention programmes within this population. However, many people within the community are unaware of, or do not believe the associated health risks (Newton et al, 2000). On the contrary, many South Asian people are familiar with the medicinal qualities of betel leaf and areca nut. As Kakde (2012) points out Ignorance of the associated health risks and the perceived medicinal benefits encouraged use for a wide range of health reasons.

The overall understanding of the literature related to healing qualities, health risks, and existing health inequalities related to paan use indicates the need to find alternative research methodologies in order to minimise limitations such

as under reporting of paan use. The current exploratory study aims to aid better understanding of how paan use developed, what it means to women and how they experience it. This can contribute to better public health interventions. The existing data on paan research lacks socio-cultural details such as life experiences of paan users; also it limits the understanding of the impact of dependence on the day to day lives of those chewing paan. In-depth exploration, can capture unquantifiable details of tobacco use which may have important implications when planning health promotion programmes, tackling health inequalities and reducing paan related harm, such as cancer and addiction/dependence. Netto et al (2010) has highlighted the importance of dedicated behavioural interventions for minority ethnic communities. Overall, the existing tobacco research related to paan use among Bangladeshi women has indicated the need to find alternative methodologies in order to understand life experiences and user perspectives and minimise under-reporting of paan use among this population.

Government interventions and public policy

While the growing inequalities have been a public health issue for a very long time, the newly elected Labour Government in 1997 took the initiative to gather evidence related to health inequalities. Tackling inequalities in health (Department of Health, 2003) is the first policy document which recognised that inequalities of health were unjust and preventable; it further emphasised the fact that most of the evidence regarding effective interventions were based on studies that have been designed to change individual behaviour and the research on wider social determinant of health were sparse (Nutbeam,

2004, see also Exworthy et al, 2003). However following from the, “Tackling inequalities in health” report, in order to address the problems raised and reduce the inequalities in health outcomes by 10 percent, the first national Public Service Agreement (PSA) was introduced by the government; the guidelines for achieving PSA targets and the way forward beyond 2010 were laid out in the “Health inequalities” document (DOH, 2008b). In the meantime, in order to review current knowledge relating to the social determinants of health and to promote the uptake of policies to reduce inequalities, WHO launched a Commission on Social Determinants of Health (CSDH) chaired by Michael Marmot.

The Marmot review in England (Marmot et al, 2010) is based on the recommendations of the aforementioned WHO initiative demonstrating government’s commitment to reducing health inequalities in England. The report includes policies and interventions that address the social determinants of health inequalities. As for tobacco, it recognises that:

- Tobacco control is central to any strategy to tackle health inequalities as smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups. Smoking-related deaths are two to three times higher in low income groups than in wealthier social groups.

- Population-wide interventions on smoking, alcohol and obesity are needed to reduce the social gradient but targeted interventions may be needed to target particular groups (Marmot review, 2010: 146).

While the report identified smoking related inequalities, the marginalisation of the smokeless/oral tobacco remains a concern.

Policy documents related to health inequalities have persistently marginalised the issue of smokeless tobacco thereby causing health inequalities among the vulnerable groups of people who are dependent on paan products. The House of Commons Health Committee report on Health Inequalities (2009) highlights their findings on tobacco as follows.

> Smoking remains one of the biggest causes of health inequalities…..Tobacco smuggling has a disproportionate impact on the poor, particularly young smokers. Some progress has been made in this area but not enough; there has been no progress at all in reducing the market-share of smuggled hand-rolled tobacco, which is smoked almost exclusively by those in lower socio-economic groups. We recommend the reinstatement of tough targets and careful monitoring now this crucial job has passed to UKBA, to ensure that it remains a sufficiently high priority. We also recommend that the UK signs up to the agreements to control supply with the tobacco companies Philip Morris International and Japan Tobacco International as a matter of urgency (Paragraph 355).

The above excerpt indicates the importance given to smoking cessation whilst the lack of urgency associated with prevention of chewing tobacco within the initiatives for tackling inequalities in health. Such discrepancies can lead to more health inequalities, especially among groups such as older Bangladeshi women in the study sample who are socially disadvantaged in terms of material circumstances in which they live and raise families.

Current provision for paan prevention: a medical point of view Although paan prevention is not a priority within the tobacco policies in Britain, there are a few treatment programmes in operation for those who are highly dependent on paan/ smokeless tobacco. These treatment plans are based on Nicotine Replacement Therapy (NRT), which is an established cessation strategy for smoking cessation. This is also known as substitution therapy; underpinning this regimen is the neurobiological view of addiction/ dependence. In general the neurobiological understanding of addiction is the basis for the pharmacological treatments for substance misuse (drug and alcohol dependence) including paan dependence. The implication of such practice is that tobacco users should be pharmacologically treated in much the same way as people with any disease or disorder. This practice is enhanced by the power of public health pronouncements made by the WHO and the Global Tobacco Research network (GTRN) that provides definitive guidelines for the tobacco related research investigations. Mair and Kierans (2007) have highlighted the way the GTRN has prioritised biomedical research and the dominant framing of oral tobacco use in WHO literature marginalises social and cultural aspects of tobacco use. Furthermore as Rooke (2013) points out tobacco use has been medicalised as knowledge has grown about the harmful effects of tobacco has led to conceptualisation of use as a problem. Indeed tobacco cessation has strengthened the biomedical framing of tobacco use by constructing nicotine addiction as a physiological-pharmacological issue. In the context of this approach, the chemical characteristics and the physiologically harmful nature of the paan mixture takes precedence. This leads to medicalisation of the problem as well as the

treatment strategy, in which pharmacological intervention becomes the panacea for addictive behaviour.

There has been a considerable amount of literature highlighting the limitations around the medicalisation (Halfmann, 2011) of health issues. In contrast as Gabe (2013) points out redefining a condition as appropriate for medical attention opens up opportunities for the alleviation of symptoms or a cure and also legitimates it potentially reducing the stigma and censure that may be attached to it. An example is excessive alcohol use being considered as alcoholism in order to treat the condition as any other organic disease, thereby taking the blame away from the individual and dealing with the problem in a more sympathetic way. While treating an issue as a medical problem has its advantages and disadvantages, as Gabe (2013: 52) highlights, it is important to retain awareness of how framing the issue in this way has consequences for the way issues are conceptualised.

In relation to paan use, the medical model misses many aspects of the experience of chewing paan, the meaning of paan and the reasons people started and continue to chew paan. For example MacNaughton et al (2012) looks at the experience of smoking and points out that the medical model of the smoking person misses key experiential aspects of smoking such as the social context of smoking, parallels with paan use. On the other hand research which looks at culturally specific meanings of smoking and practices related to smoking (Highet et al, 2011) can deliver a much stronger insights into the social contexts that the practice takes place in and the meaning of smoking which could form the basis of better targeted interventions. However, presently, there is a paucity of data on the effectiveness of interventions for

health improvement by ethnic or racial group and there is little evidence about the effectiveness of more focused interventions (Bhopal, 2006). There is a need to know more about how effective targeting is being and whether it is based on a strong understanding of practice. In the meantime the medical view that addiction resides solely within the individual continues to foster significant limitations across addiction theorising, research and treatment (Graham et al, 2008).

Many theories of substance abuse have been criticized for failing to attend sufficiently to social and contextual factors (Coppelo & Orford, 2002). In the mean time strong arguments have emerged pointing out that substance use and addictive behaviour can be understood more fully if set in social and cultural context. Sociocultural theories see addiction as a result of socio-cultural and environmental problems. Substance use disorders do not occur in a vacuum; the cultural norms of a society and the negative effects of society on individual behaviour can cause addiction. Some researchers (DiClemente, 2003) who advocate behaviour change emphasize the role of societal influences, peer pressure, and family systems on the development of addiction. Therefore, social and environmental influences must be taken into account as causal factors or factors that place individuals and, in some instances, entire communities at risk for these disorders (Cavaiola, 2009). It has been theorised that environments with greater levels of available positive reinforcement in general may make it less likely that a particular positively reinforced behaviour, such as substance use, will occur (Carroll, 1993). Socioeconomic factors are closely related to substance dependence

regardless the type of substance. Tobacco addiction is not any different. Cavaiola (2009) points out that it is not unusual to find that substance use disorders are more prevalent in areas that are gripped by poverty, racism, and a lack of occupational and educational opportunities. Although this is a useful concept in understanding some aspects of addictive behaviour related to the environmental factors, it does not explain the behaviour of the majority of the people who are not affected by the same environmental conditions. As noted in the section above this also presents another problem; published studies tend to explicitly or implicitly associate membership in a particular ethno cultural subgroup with a problem aspect of psychoactive substance use and this can lead the reader to develop the perception that a psychoactive substance-use problem is somehow even more serious because it occurs in a particular subgroup and that the problems associated with that subgroup are worse because they involve psychoactive substances. This demonstrates the problem of classifying paan use as a substance misuse.

Furthermore it raises the issues of cultural awareness and sensitivity that is needed when dealing with substance users regardless their status of addiction and hence the importance of conducting culturally sensitive research based on user perspectives. Rather than focusing on the addiction criteria, which the majority of the addiction questionnaires are based on, exploring the experiences of the users can highlight the positive and negative aspects related to habitual use. This is important in understanding the multidimensional aspects of substance use which is an integral part of the development of user based interventions. For example Hilary Graham's (1993) research findings with housewives have contended that feelings of

psychological well being are the most significant positive effects of tobacco consumption. Other researchers Poland et al (2006), Bell et al (2010b) have argued for further understanding of the social context of psychoactive substance use among socially and economically marginalised groups because there may be socioeconomic reasons associated with their substance use. These reasons need to be taken in to account when designing and developing cessation and prevention programmes. This illustrates the importance of understanding substance use from different perspectives as there is no single theory that can explain all aspects of substance use and addiction. The three elements the user as an individual, the nature of the substance in terms of its addictive capacity and the environmental circumstances, all of which together are causal in manifesting addiction. However, the current provision of tobacco cessation focuses mainly on the addictive nature of nicotine rather than the environmental circumstances. Bangladeshi women's environment plays a significant role in paan use which has become a major risk for their health.

Summary

Government policy documents including the Black Report and the Health Divide have recognised the existence of health inequalities in terms of gender ethnicity and socioeconomic status and implemented some measures to reduce these inequalities. However, problems which are specific within certain groups of people, such as the use of paan which is also known as smokeless tobacco continue to be neglected and marginalised in government tobacco policies. Research has uncovered a prevalence of paan use among

Bangladeshi women which is of concern however; the health inequalities related to paan use is still to be acknowledged by the health professionals. Focusing on the population under study, it is clear from the evidence presented, that Bangladeshi women in the study are a vulnerable and socially disadvantaged group in that they have experienced the socioeconomic problems associated with migrant groups. Furthermore, as research evidence shows, distinctive to them is the practice of harmful use of paan, which is associated with numerous health problems and addiction that need to be addressed. Employing an ethnographic approach, the current study was able to explore women's experiences of paan use through their biographical trajectories and examine how paan use is tied into their self identification, their efforts to create home. Furthermore, it was possible to look beyond stereotypical cultural explanations and understand the personal, environmental and social circumstances that influenced the development of paan use within the context of their lived experience.

CHAPTER 3 METHODOLOGY: THE NATURAL HISTORY OF MY RESEARCH

Introduction

Previous chapters have raised the concern that tobacco research studies across the globe have mainly contributed to knowledge regarding the physiological effects of paan use. However, the socio-cultural aspects of paan chewing remain under-researched and poorly understood. The majority of epidemiological research related to tobacco chewing was carried out either by using laboratory experiments or by quantitative methods using predesigned questionnaires and pre-existing data related to problems associated with tobacco or areca nut. Weiss (2001:6) points out that useful guidance for health requires consideration not only of the classical epidemiology of diseases and disorders, but attention also to the local experience of illness, its meaning, and both risk-related and help-seeking behaviours in the community. Transforming this agenda into an operational framework requires innovative integration of frameworks and a mix of qualitative and quantitative research methods. Furthermore, some existing research related to tobacco (Farrand et al, 2001; Netto et al, 2010) have established the need for culturally specific research and interventions, as well as the importance of cultural and linguistic competence in delivering health advice. Therefore, it is clear how important it is to understand people's experiences, the meanings of behaviours and the socio-cultural context in which their use of paan takes place. This focus requires a methodological approach that would explore; the socio-cultural significance of paan use, the complexity of behaviours, relationships and the contexts of social interactions

in order to inform prevention and health promotion intervention strategies for addressing inequalities in health related to paan use. This places the background of this current research, the aims of which are to investigate the phenomenon of paan chewing from the point of view of a small group of Bangladeshi women, within the qualitative tradition. As discussed in chapter two, currently, there seems to be more qualitative approaches using narratives when researching health issues. While qualitative research is neither prescriptive nor definitive it can provide valuable information about individuals and groups. It can also prompt new questions and situations in the process of seeking knowledge.

Hughes (1990) points out that methodologies lay down the procedural rules by which reliable and objective knowledge is said to be obtained. According to Hughes, the choice of data collection technique is not always dictated by the problem at hand, but often by prior preferences or the commitment of the researcher for a given methodological position rather than out of practical expediency. However, as Blaikie (2000) states, sound methodological practice is to choose a method appropriate to the research question (see also: Mason, 2002; Creswell, 2003). This thesis is an exploration of peoples' experiences and the meanings they attribute to habits and behaviours. Hence it requires an approach that will allow an authentic and honest conversation between the researcher and the researched with no preconceived hypothesis (Glaser and Strauss, 1967; Strauss and Corbin, 1990).

Hammersley and Atkinson (1995) showed that ethnographic research permits the researcher to explore and know the social construction of reality related to

the topic under investigation (see also: Brewer, 2000; Hughes et al, 2002). The researcher then builds a complex, holistic picture, analyses words, reports detailed views of informants and conducts the study in a natural setting (Cresswell, 1998). The methodology of the current study is designed to build that holistic, socio-cultural picture of the experiences of paan chewing among the study population.

In-depth exploration of paan use from older Bangladeshi women's point of view has not been studied before. Thus, this study is of particular importance to health professionals. It will contribute to a better understanding and awareness among health workers who have the potential to help Bangladeshi women with the knowledge and skills to enable them to make informed choices about their paan use. For example, if health workers are able to identify the symptoms of use and withdrawal related to chewing paan, they will be able to give appropriate advice or signpost Bangladeshi women to relevant services such as community pharmacists and tobacco cessation programmes. Furthermore, health workers may be able to set up self-help and educational groups that can offer appropriate services for paan users.

The ethnographic study was conducted in two phases, consisting of a period of field work, followed by in-depth interviews. The field work phase was designed in order to employ several methods of data collection such as closely observing activities with Bangladeshi women, meeting other significant stakeholders (health professionals and paan vendors), participant observations, focus groups and visits to places of significance (mosques, schools, hospitals, dental and general practitioner surgeries and other

relevant venues). Phase two was in-depth interviews with 30 Bangladeshi women aged over 50 years. Semi-structured interview data was recorded, transcribed and analysed using the principles of Grounded theory which may be defined as 'the discovery of theory from data systematically obtained from social research', (Glaser and Strauss, 1967: 2). Although an enormous amount of data was collected by using multiple methods, this process was time-consuming and labour intensive. Hence, the aim of this chapter is to present 'the natural history of my research' (Silverman, 2005: 305).

The chapter begins by outlining the reasons for using ethnography. This is followed by a section describing the ethical considerations involved in researching a potentially vulnerable population. The discussion will then move on to consider the 'insider outsider perspectives' involved in this research before describing the research process in detail. This will be followed by the researcher's reflections before the conclusion.

Rationale for ethnography

The origins of ethnography are traced to Malinowski's fieldwork among Trobriand Islanders in 1914 (Ellen, 1984: 15). Ethnographic methods were initially developed by anthropologists working in Britain and in North America. British origins were tied to the needs of the British Empire to understand the cultures and groups that the British were seeking to rule once the period of colonial conquest had been completed and assimilation into the 'British family of nations' was possible (Brewer, 2000: 11). According to Brewer, the researchers of the Chicago School of Sociology developed observational

techniques to explore groups on the margins of urban industrial society in the United States. Recently, there has been an increasing tendency to undertake studies in applied fields such as education and health care (Atkinson and Hammersley, 1994) where in-depth exploration is sought. Hodgson (2000: 4) points out that ethnography within the healthcare context is valuable for a number of purposes including the exploration of cultural perceptions of the people affected by illness, and even the cultures of health care workers. It has been used in a number of studies relating to perceptions of illness (Good, 1994; Gerrish et al, 2013). For example, using ethnography to explore experiences of the diagnosis and management of tuberculosis from the perspective of Somali patients and healthcare professionals involved in their care Gerrish et al (2013) concluded that nurses have a role in promoting early presentation, timely diagnosis and treatment adherence through supporting Somali patients and raising awareness of the disease among primary care practitioners.

To explore people's experiences in an area about which only little is known, such as paan use among Bangladeshi women, it was necessary to choose a methodology that would give flexibility to use multiple techniques for collection of data so as to maximize and diversify access to information. In this study, in addition to collecting data it was essential to understand the setting as well as to participate and become involved in individual and community activities. As stated by Brewer (2000: 59);

Ethnography is not a particular method of data collection but a style of research that is distinguished by its objectives, which are to understand the

social meanings and activities of people in a given field or setting, and an approach, which involves close association with, and often participation in, this setting.

When researching culturally specific phenomena, ethnography can be considered as useful and the most appropriate approach (Fetterman, 1998; Hughes et al, 2002), in that it can also enhance understanding of barriers to access help when needed. By addressing those requirements, and also transforming the public consciousness and common sense about the disadvantaged in society, ethnographic research can help the very people being studied, (Fine et al, 2003). However, researching disadvantaged people needs extreme sensitivity because as Bulmer and Solomos (2004: 7) observe, ethnic identities (or identities in general) are not fixed but have evolved: they are subject to “the continuous play of history, culture and power”.

From a methodological perspective, ethnography falls within the naturalistic approach in which not only the world of the researched should be examined in its natural state, but the researcher should also adopt an attitude of respect or appreciation for the social world. The ultimate goal of ethnographic research is to describe the culture or subculture in as much detail as possible, including language, customs, values, religious ceremonies and laws that often involve becoming a participant observer and re-socialising themselves into the culture under study (Bailey, 1994: 249). This means that the investigator becomes the research instrument, and this can create problems such as bias and subjectivity. Therefore, the researcher needs to be reflexive about the social process that impinges upon and influences data gathering (Brewer, 2000:

127). Issues related to reflexivity will be discussed later in the chapter. Although bias and subjectivity are a risk, it allows a richer vein of data to be appraised and is valuable in contexts in which "natural history" is central (Hammersley and Atkinson, 1995: 16). Another important aspect of conducting ethnographic research is to be aware of the insider/outsider dynamics of the researcher and the researched.

Insider/outsider perspectives in doing ethnography

Kenneth Pike (1954) suggested that there are two ways, insider (emic) and outsider (etic) perspectives that can be employed in the study of a society's cultural system. The 'insider' perspective focuses on the intrinsic cultural distinctions that are meaningful to the members of a given society. The outsider perspective relies upon the extrinsic concepts and categories that have meaning for scientific observers. If, the 'etic' constructs of paan and its ingredients relate to the conceptual schemes and classifications of the scientific and medical research community then investigating the emic perspective needs to focus on the everyday experiences and meanings of paan use studied in an unobtrusive manner (Rosenthal, 1989). This approach allowed the exploration of the relationship between the social role of paan and the Bangladeshi women's views and understanding about their lifestyle along with the environmental details of their habitat, which is an integral part of their way of life in Tower Hamlets.

This kind of approach, investigating user perspectives and awareness of medical professionals has been tried in India and Indonesia (Nichter, 2006).

Based on their findings, Projects Quit Tobacco International is to design a tobacco curriculum for medical colleges, develop culturally appropriate approaches to clinic and community-based tobacco cessation and build tobacco research and training networks within India and Indonesia as a prototype for other countries. However, in this study, fieldwork required engagement with not only the Bangladeshi population, but also with the other relevant stakeholders and the physical and social environment of the participants. There seems to be an assumption among some qualitative researchers (Armstrong, 2001) that being a member of the researched group provides easy access as well as a level of trust and openness to the study group. To be an insider, one has to be a member of the researched population (Kanuha, 2000). This is debatable in terms of what constitutes the membership within a population; is it the language, social class, religion, employment status, education or even the lifestyle. According to Asselin (2003), as an insider, the researcher shares an identity, language, and experiential base with the researched group. However, identities are not fixed and people have multiple fluid identities; religion, gender, social class, education and endless number of characteristics can influence identity and identification by others (Gunaratnam, 2003). Fluidity of identities gives rise to fluidity in insider/outsider relationship. A researcher can share some aspects of identity with the researched population. In this research, it was possible to be seen as an insider because of the commonality of Asian origin and status of being a woman. Being also viewed as an outsider came because of the manifold identities that the participants had that were not the same as my own. Naples (1996: 83) points out that ‘outsiderness’ and ‘insiderness’ are not

fixed or static positions, rather they are ever-shifting and permeable locations that are differently experienced and expressed by community members.

If a researcher identifies as an insider, questions are raised about objectivity, reflexivity and authenticity of the research carried out as an insider. One of the problems with the insider approach that researchers (Crow and Allan, 1994) have highlighted is that an insider may be over familiar with the society and/or phenomena being studied (see also: Crow et al, 2001). As Kanuha (2000: 444) indicated, perhaps an insider researcher knows too much or is too close to the project and may be too similar to those being studied. For example, Armstrong (2001: 243) referring to a study she carried out as an insider, points out that her empathy and enthusiasm for a subject dear to her own heart may have kept the participants from considering certain aspects of their own experience. On the other hand, where there is no language barrier, depending on the sensitivity of the topic, groups may prefer an outsider. This is mainly due to the issues of confidentiality since participants might feel reluctant or embarrassed to disclose problems to an insider. As Naples (1996) states, being an outsider can become a resource through which a researcher is able to acquire an insider perspective. In a study that was designed to examine how economic and social restructuring is reshaping the lives of residents in rural towns in Iowa, she was able to highlight the extent to which residents with a diversity of social, economic, and demographic characteristics experienced feelings of alienation from the perceived community at large. Furthermore, as Fay (1996: 20) points out sometimes being an outsider to the group being studied, can enable the researcher to appreciate the wider perspective with its connections, causal patterns, and

influences, than one also internal to the experience. However, it should be noted that the identity of the researcher and interactions with research participants need attention, although notions of ‘insider’ and ‘outsider’ status are complex and there are no simple rules regarding ethnic matching (Gunaratnam, 2003). Furthermore, it is necessary to be aware that research has often reproduced inequality, and that the relationship between researcher and researched is very sensitive as power inequalities can be involved. Beyond ethnicity and gender it is possible that education and class can also be important, and it is crucial not to make assumptions.

Having worked with Bangladeshi women for over two decades on various health promotion and educational projects, there was some previous knowledge about certain aspects of their environment. Furthermore, as an Asian woman, there were some shared experiences that made it easier to immerse myself in their social environment, somewhat like an insider. The Indian sari, similar food such as rice and curry and Indian music all of which were familiar to both the parties and it was easier to socialise with them. It was possible to talk about children, husbands, weddings and saris and almost anything that mattered to us as women or as mothers. Critically, this also made it easier to elicit valuable interview data about their everyday lives, their domestic home-making practices, such as their ambitions, aspirations, likes and dislikes, value systems, religious convictions and many other aspects of their social world. However, as Gunaratnam (2003 :12) points out, ‘although commonality can be seen as a form of empathic identification, it is vital that such empathy is interrogated and grounded in the recognition of the

researcher as a separate and interactionally powerful producer, listener and interpreter'.

In addition to the status of being an insider or outsider, values and beliefs along with sociocultural background that form one's fluid identity can shape the research process. Initially the familiarity and the rapport with the study population worked well. However, the assumptions related to the feeling of being in an extremely privileged position to conduct an ethnographic study (because of my being an Asian woman), had its limitations. For example, in addition to the similarities between the researcher and the researched, there were many differences related to socio cultural backgrounds that led to different values and beliefs which formed our different and fluid identities (the participants believed in ghosts and I did not). Finding ways of compromising and negotiating the differences which may lead to tensions is a skill that is essential as an ethnographer. The researcher has to be aware of the way the identity of the researcher may affect the research process and be sensitive to the dynamics of the acceptance and reservation mechanisms that can occur throughout the interview processes.

Identities of the researcher and the researched are central to the methodologies in exploring sociocultural worlds of the researched population. The way identities can shape the research has been already investigated by feminist researchers (Reed, 2003). In this study as women, the researcher and the researched shared some commonalities or 'partial identity' (Harding, 1987) with the respondents. This was beneficial. As Reed (2003: 20) points out:

> The benefit of the partial identity perspective is that it recognises both differences and similarities in women's experiences. While there are differences in experiences, positioning, and power relations between women there are also commonalities….These tensions and commonalities can help to build rapport within a research situation while acknowledging women's differing experiences.

While it is important to recognise the aforementioned tensions and commonalities as well as acceptance and reservations, it is equally important to acknowledge that, similar to the concept of identity, the sense of being an insider or outsider is also a fluid and complex notion. The success of the ethnographic research interview ultimately depends on the circumstances and the skills of the researcher and the method of research process. Stanley and Wise (1993) argue that academic feminists, should be less concerned with the choice of method and technique and much more concerned with the epistemological bases and claims of different styles of feminist research. As Dwyer and Buckle (2009: 57) show the core ingredient is not the insider or outsider status but an ability to be open, authentic, honest, deeply interested in the experience of one's research participants, and in being committed to accurately and adequately representing their experience. In addition, ethical issues need be taken in to account at every step of the research process. This will ensure the safety and well-being of the research participants.

Ethical considerations

It has been long established that when researching non-mainstream groups, researchers need to tailor their data collection techniques to the sensitivity of the topic and the vulnerability of the subjects (Lee, 1993; Hobbs, 2002). Due to the exploratory nature of the present study, in addition to the BSA research guidelines, the ethical issues of the seven research stages of thematising, designing, interview situation, transcription, analysis, verification and reporting (Kvale, 1996:111) were maintained.

Due to its very nature, it is not possible to determine all ethical issues in an ethnographic study. However, it is possible to anticipate situations where ethical issues may arise in natural settings. For example, during the pilot interviews family members (husbands and relatives), started showing interests. This meant that either they may observe or answer questions directed to the wives. Researchers need two attributes: the sensitivity to identify an ethical issue and the responsibility to feel committed to acting appropriately in regard to such issues (Eisner and Peshkin, 1990: 244). Negotiating written consent was an extremely sensitive issue. This was mainly due to their reluctance based on past experience in signing official documents, which they perceived as suspicious. However, at the end of a lengthy explanation, it became possible to obtain participants' written consents as well as the agreement for recording.

An interview inquiry is a moral enterprise. The personal interaction in the interview affects the interviewee and the knowledge produced by the interview affects the understanding of the human situation (Kvale, 1996: 109). It is

debatable that this same understanding may have the potential to either sanction or endorse a practice that health interventions seek to problematise. This is perhaps unavoidable as, similar to smoking; paan use has already been problematised by the scientific research community. As for the consequences for the women in the study, during the pilot as well as in research interviews, the women became more aware of the paan habit and wanted more information. During the pilot study four women wanted to meet me for further discussions to ask for help for paan cessation. The respondents reported that paan use had been a concern for them for some time, but did not have any opportunities to raise the issue. Following this better preparation was made to provide support for respondents should they need it for the main study.

Information packs were prepared to be given if necessary guiding them towards sources of more information, if the respondents sought further help. This has been a recurrent ethical as well as a methodological issue throughout the study. It was not possible to ignore the signs of dependence. For example, all the respondents reported that they needed to chew paan within half an hour of waking up in the morning. This is discussed in detail in the findings chapter, however, a researcher should be responsible for raising an issue which triggered participants' concerns about an issue which has not been a greater problem before. The fact that the research process has problematised paan use raised an ethical dilemma. There was a moral obligation and an ethical responsibility towards the respondents, in terms of taking some action or at least minimise their anxiety, especially when they have asked for help. It became clear that it was necessary to give an extra

time after the interviews to listen and discuss the anxieties of the respondents and take appropriate actions before leaving the respondents.

Giving extra time after the interview has been recommended by other researchers. Alty and Rodham's study (as cited in Liamputtong, 2007: 42) recommended a debrief session after the interview in order to assist participants and provide an opportunity to talk about their anxieties. There are other researchers (Paradis, 2000) who advocate that participants, who need help, should be referred to support services. In order to manage such situations a parallel ethical protocol based on anticipated ethical issues was drafted. In addition to gaining written verbal consent, the aim of the study was explained along with the details of the right to withdraw from the interviews at any point. Confidentiality was assured and the participants' anonymity was maintained throughout the study. It should be noted that due to the light-hearted nature of the informal conversations, there were no emotional disturbances or calamities. However, there were some concerns related to dependence and, information related to further advice and support services were given to those who requested. Since there are not many support services available at present, it became necessary to give space for the respondents by listening to their concerns hoping this would help reduce their anxiety. This approach helped to maintain a healthy and trusting relationship with the respondents as well as to fulfil ethical commitment towards the study population.

Phase 1: Fieldwork

Fieldwork is an integral part of the initial stages of the study. Burgess (1982) described ethnography as field research that involves the study of real life situations. Field researchers, therefore, observe people in the settings in which they live, and participate in their day to day activities. Hammersley (1990) pointed out that the aim of ethnographic research is to study people's behaviour in an everyday context rather than in simulated or experimental circumstances created by the researcher. David and Sutton (2004: 362) argue that the rationale in ethnography lies in the premise that the researcher should go to those they research, rather than for the researched to enter contrived research conditions set up by the researcher.

The fieldwork setting was the London Borough of Tower Hamlets and surrounding areas of East London. The first week of the fieldwork was an orientation. It was essential to understand the environment and the way the respondents fitted in to that surrounding. Furthermore in the day to day lives of Bangladeshi women, there are other social actors with whom they interact on various circumstances within their environment. It is intrinsically important to develop ways of gaining access to the world of these other individuals in the context of their daily life (Schwartz and Jacobs, 1979).

The London Borough of Tower Hamlets held a wealth of information related to Bangladeshi women's activities. While it was crucial to understand the physical, social, cultural and economic context in which Bangladeshi women lived, formed relationships, attended events and services for social and health care needs, worked, shopped, raised children and interacted with other local

residents; it was also important not to carry any preconceived ideas acquired as a health practitioner to the site. Thus, the field work was commenced with a blank notebook and a pen to document the observations and other information that seemed relevant to the study.

As Miles and Huberman (1994: 42) suggested, there were some 'orienting questions, observations, headings and a document analysis form'. Fieldwork consisted of visits, meetings and observations (structured and spontaneous). Several visits to the local borough council and libraries provided statistical information as well as the much valued historical information of the East End. Silverman (2005: 251) pointed out the importance of being meticulous in record keeping and reflective about data. This was followed throughout the research process, and it helped immensely during data analysis. As Richardson (2000: 923-49) suggested, field notes were organised into four categories in the research diary. They were the observation notes, methodological notes, theoretical notes and personal notes. Information related to the people and the environment of Tower Hamlets was collected by various techniques which were flexible and unstructured to avoid leading questions that impose categories on what people say and do. In the first phase, 11 months were spent from February 2009 to December 2009 in Tower Hamlets, the site of the research investigations. Phase 1 was designed as a precursor to the phase 2, in-depth interviews with the selected respondents. The analysis of data collected during the fieldwork, was treated as a 'dry run' (Silverman, 2005: 63) for the main study.

Investigating key stakeholders

One of the key features in delivering culturally and linguistically competent health promotion is to work with the key stakeholders who may have some influence in the health of individuals and their communities. For example, the health professionals I met have public health concerns about paan use and they believe that the paan habit is injurious to health. The shop keepers are of the opinion that paan is good for health. It is pertinent to understand their points of view, their roles as well as their power relations within communities. Obrist et al (2003) pointed out the need to develop more detailed accounts of interactions among the various stake holders that play a role in urban health.

Stakeholders are often either gate-keepers for the groups under study or individuals with some interest in the topic of research; some of them were group leaders and others were health professionals who had an interest in the topic of tobacco cessation. While these stakeholders are important, they are often powerful and their views may be at odds with or even silence the groups being researched. In terms of access to the respondents, these stakeholders did not have any influence. Nevertheless, their direct or indirect influence on the health of community members cannot be denied. Hence, their views about paan use were important to the study for the following reasons:

- The School of Dentistry in Tower Hamlets has conducted the majority of research related to smoking and paan consumption among the Bangladeshi population. Currently, there is a community outreach programme (Stop Tobacco Project) for tobacco cessation. The staff members are able to give an overall view about the project.

- General practitioners and community health nurses have raised their concerns about oral hygiene and other tobacco-related health problems within the Bangladeshi community.

- Paan vendors in East London are introducing varieties of new paan products without any legal restrictions; these are available in Asian shops.

- The role of trading standards officers in relation to the availability of paan products; there are no legal requirements for the sale of paan and dedicated paan shops are a familiar sight in the East End.

In addition to the people mentioned above, there are others who play a crucial role in the paan industry outside the scope of this research. For example, the paan lobby in India plays an active role in promoting paan products within India and overseas. British and American Tobacco Companies are instrumental in increasing tobacco consumption in the developing world. In the past, tobacco billboards were a familiar sight in the highways of Bangladesh and other developing countries. There are other stake holders including players in local networks and community-based organisations, the government and city authorities as well as international organisations (Obrist et al, 2003: 107). The understanding of these stake holders is an integral part of the current study and the ethnographic approach provided the flexibility needed to engage with conflicting constructions of paan use in this context.

In the capacity as gatekeepers, stakeholders can sometimes have the power to access resources, make decisions, implement policies and in general be able to bring about social changes. Khanum (1994) employed a similar ethnographic approach in exploring Bangladeshi women's experiences in the

concept of illness and causation of disease. Khanum's study highlighted how the 'norms' of Bangladeshi culture and 'racism' are used as means of retaining the class-based interests of a particular group in society. This creates boundaries between different groups, hindering the less privileged groups' access to the indispensable forces of social change. Therefore paan culture should not be ignored as only a cultural norm which has positive recreational aspects, but needs to be treated as a health risk of a vulnerable group of people. The involvement of stakeholders, such as health professionals, is paramount in this venture.

Meeting with Health Professionals

Published literature on areca nut and betel quid chewing is unanimous in its concern for oral cancer and other health-related problems (WHO, 2005; 2012). There are health awareness campaigns related to tobacco chewing in Tower Hamlets. This meant that health professionals were very important stakeholders who contributed to research as well as preventative strategies of tobacco use. They are also powerful in terms of influencing health policies and, therefore, their involvement and understanding is vital for the current study. However, in the presence of a health issue, there is a tendency for some medical professionals to see people as patients. For example, often the diagnosis is based on the physical symptoms and personal and social circumstances of the people are rarely taken into account. When this happens, the health issue becomes a medical problem. On the other hand, social scientists (Reed, 2003; Keval, 2009) have emphasised the importance of meanings people attribute to health problems. If all parties can work

together, holistic engagement with the health professionals and the users can bring about positive changes in the way paan use is addressed within the medical profession.

Working with medical professionals may present particular challenges to researchers - social researchers have reported their difficulties when interviewing elite groups and individuals (Ostrander, 1993). As Ostrander points out, few social researchers engage in studies involving members of elite groups. Reasons for this include difficulty in recruiting participants who, by the nature of their status, are fewer in number and have established barriers to set themselves apart from the rest of society (Hertz and Imber, 1995). However, the experience during this study was positive. Due to the unfamiliar nature of the subject under study and the familiarity with health problems related to tobacco, the health professionals showed a great interest in exchanging ideas and opinions about the paan habit and the research population. Thomas (1995) suggested that elite respondents may prefer to direct the interviews and talk to their own agendas. The interview guide had contingency plans in case of such difficulties. However, gaining access to the elite health professionals was easier than expected. The health professionals' curiosity and interest in paan was an advantage. They also had a genuine health concern about paan use among Bangladeshi women and they were willing to be of help to anyone who was interested in this under-researched 'problem' as they perceived it.

In order to gain an insight into the understanding of local health professionals, meetings were held with four general practitioners, a dentist, two professors

involved in paan research since the last two decades, two health visitors, one midwife and a hospital consultant attached to the Royal London Hospital. All the health professionals had concerns about oral cancer among Bangladeshi women. The dentists complained about the poor oral hygiene of Bangladeshi patients. The health visitors and the midwife related their personal experiences that gave rise to new ideas for exploration. According to their information, mothers believe that chewing paan while breast feeding helps babies to sleep well. They were concerned that tobacco addiction in mothers, may lead to nicotine dependence in babies. There is no research material on this issue as yet. During in-depth interviews the issue of chewing paan while breast feeding was raised and it seemed common knowledge among Bangladeshi women. The hospital consultant gave a good description of health problems he encounters on a daily basis among Bangladeshi women; oral cancer, dyspepsia (heart burn) and asthma seemed to be paan related illnesses. The findings from the stakeholders helped in reorganising the interview guide in preparation for the in-depth interviews.

Meeting with local Bangladeshi people

The aim of meeting local people was to gain an insight into what they thought about living in the area of the research site, the London Borough of Tower Hamlet (LBTH). During my work in East London, I have heard phrases such as " inner city", "deprivation", "overcrowded", "dirty", "Bangladeshi", "council housing", "immigrants", all of which contain negative connotations. Therefore the initial aim was to get a general idea about how Bangladeshi people felt about the place. The statistical information related to LBTH gave an outline of

the current transition through which LBTH was going through as well as the knowledge of the services available for people in the borough.

As Brewer (2000: 80) recommends, researchers should sample field sites in such a way that they have multiple fields around which they can move easily and so make comparisons. The selection of other fieldwork locations in this study was based on the information gathered during these initial meetings and five criteria as proposed by Burgess (1984: 61); simplicity, accessibility, unobtrusiveness, permissibleness and participation. In addition to the prearranged meetings, spontaneous conversations were used with ordinary people going about on their day to day business of shopping, commuting or waiting for public transport. This way, it was possible to speak to many people in Tower Hamlets.

Participant observation

Participant observation is used in the ethnographic method to learn the diverse perspectives held by study populations. Since it has the greatest potential to uncover contextualized, otherwise inaccessible perspectives, it ontologically and epistemologically underpins the human quest for understanding multiple realities of life in context (Rossman and Rallis, 2003). The review of literature on participant observation revealed a diversity of terminology. Originally, Schwartzman and Strauss (1973) referred to the technique as 'field method', and later Burgess (1982) used the term 'field research' and viewed the researcher as the main instrument of data collection in participant observation. However, it should be noted that in the current study this activity is only an element of the fieldwork. There was no intention

to analyse each and every conversation, but the main outcomes were recorded for the purpose of reference, possibly for later use in the research.

The London Borough of Tower Hamlets has several venues that offer a range of social and educational activities for community groups. As for Bangladeshi women, there are groups for literacy and numeracy, Koran reading, health promotion, tobacco cessation, mother and toddler activities, drop in sessions for advice and information, keep-fit and leisure and several other activities. It was possible to visit these venues and activities to learn what went on within the study population. In order to ensure the anonymity of participants, the details of the venues are not disclosed in the thesis.

Four groups were chosen for participant and non-participant observation. Overt observation was used as there was no need for covert observation. The topic 'paan' use is a health related issue which attracted the attention of group leaders who were potential gatekeepers. As Brewer (2000) pointed out, gatekeepers are those who have the power to grant access to the field and at lower levels in the organisations or groups there are usually a number of informal gatekeepers who can affect access. The community group leaders seemed to be very positive and with their help it was possible to negotiate access to the groups. I was introduced to the group as a person interested in paan culture among Bangladeshi women, but not as a health professional or a social worker. During the tea break, it was possible to mingle with people and ask questions about several aspects of living in Tower Hamlets.

The aims of participating in these groups were twofold; firstly, to observe what role paan plays in these group meetings and secondly to broaden the

research by employing a variety of methods for information gathering. Lofland and Lofland (1984) emphasised that using a variety of ways of information gathering to extend the range of data combination makes possible "triangulation" (Denzin, 1970) – a process that involves corroborating evidence from different sources to match or compliment a perspective or a theme. Field work notes served this purpose extremely well. In relation to little researched behaviours and populations this wider approach is invaluable in providing information to create research instruments.

Observational studies also allow for an examination of events, as opposed to relying on self-reported behaviour, and can serve to highlight gaps between views and actions (Pope and Campbell, 2001). In addition, it also enables the researcher to compare the observation notes with data gained through in-depth self-reported statements. As Schensul and LeCompte (1999) described, groups and individuals were tracked in their natural settings over a long period of time in order to gain orientation within the community in Tower Hamlets. Koran reading and Health promotion are two different types of groups among the few (6) I attended.

Spradley (1980) pointed out that a researcher may adopt five different levels of participation: complete, active, moderate, passive and non-participation, all of which were adopted during the field work. In participant observation, there was opportunity to be involved in two groups, moderate participation in one and a non-participatory role in the other. I intended to take part in the activities and document the event in the first group, and to remain as a silent observer and document the event after the end of the session in the second

group. In both instances, the role was negotiated with the group and the facilitators after explaining the aims and objectives of the research.

It is possible to think that the authority of professional roles can be viewed as affecting the relationship between researchers/researched. The participants were familiar with regular visitors attending the groups for delivering health talks or information related to social and health services. In addition, it was explained to the participants that they were the 'expert users' and the researcher's job was to learn their experiences, in order to minimise any perceived power imbalance. The participants did talk freely and documentation was done after the event so as not to attract unnecessary attention which may have hindered the normal participation.Field notes from both group observations and the reflection memos were used to improve the design of other methods. For example, when they were discussing healthy food, it was possible to gather names of places where they shopped. In another visit to these places, I met the respective shop keepers who obliged me with a concise account of all the tobacco products available in their shops. Another benefit of participant observation was that it helped to ensure that cultural appropriateness and relevance were incorporated into the interview questions, follow up queries and probes. In addition attending the groups enabled an opportunity to see the participants' social networks. For example, it was noticeable that some participants came and left together. Others came individually. Some women interacted with each other more than others who kept to themselves. It was possible to have a conversation with the quiet members of the group later, after the group session.

Field work visits and observations

Visits were made to six GP surgeries, two hospitals, seven community centres, four schools, ten Bangladeshi shops, one dental school, two Koran classes, three English classes and three Keep Fit classes. These visits helped to observe people, ask questions, clarify issues and discuss matters further when there seemed to be gaps in understanding or within the data collected. Their answers demonstrated the lack of public health awareness about chewing paan.

Six informal fact finding home visits with a colleague made it possible to observe the homes of Bangladeshi women. Some houses had industrial machines indicating working from home. They also had Bangladeshi art work and paintings that originated from Sylhet. Every house had a brass 'paan daan' (a small pedestal tray or receptacle with paan), areca nut cutters and other artefacts (see Appendix). These visits helped to become familiar with the environment of Bangladeshi households before conducting the in-depth interviews. For example, I learned some of the colloquial terms used by Bangladeshi women. Furthermore, the visits helped to think over how to organise phase two of the research and in particular, the sampling strategy.

Focus groups

Focus group methodology is one of several tools used to generate information within the exploratory research. It is particularly suited for obtaining several perspectives about the same topic (Gibbs, 1997). It is a type of facilitated group interview designed to elicit information and discussion of the phenomenon under study, in a flexible way. It is open in nature and

considered to be naturalistic (Krueger and Casey, 2000). Focus groups help the researcher to access the language and cultural constructions of groups (Duncan and Marotz-Barden, 1999). There are some disadvantages to focus groups. If not managed well by an experienced facilitator, some participants in the group can dominate the discussion, thereby discouraging any contribution and even disempowering some group members. It is therefore, important to have an experienced facilitator who can navigate the discussion to ensure equal participation. It is not possible for findings of focus groups to be projected and generalised for a bigger population. As Fern (2001) pointed out, focus groups are not useful in making generalisations, but extremely helpful in generating new knowledge as well as in triangulation of findings from main data analysis. Hence, it was used as a complementary and additional technique in field work. For example, based on the findings of the focus group, it became easier to design the language and focus of questions used in the interviews. It was also possible to see behaviours that would not have been observed otherwise. An example is a discussion about different brands of tobacco paste. This was new information because the assumption is that tobacco leaf is the ingredient found in the paan mixture. Following the focus group, it became clear that there was a need to explore the varieties of tobacco pastes available in Bangladeshi shops. Furthermore, the focus groups also helped explore and clarify the differences between the group this research focuses on and younger women. While the epidemiological data identifies older women as using paan more than younger women, as vulnerable to health issues relating to paan use and as being in a particular socio-cultural situation as first generation migrants – the focus groups helped

explore and clarify the different practices, views and life situations of the different generations. This strengthened the emphasis of the study on this age group and also shone light on the relationships between women and their daughters, a key aspect of women's self-identification.

The groups selected for visiting and observing were held in centres where Bangladeshi women met on a regular basis. These groups are organised by community leaders for housewives and other interested individuals. Outreach workers from different organisations such as the diabetic association conduct workshops for these groups. Two focus groups, one with six women (age 45-65) who chew paan, and the other with six young unmarried women (age 20-25) were observed on two different days. The older group shared similar attitudes to some issues, such as child rearing expectations, choosing a partner for marriage and higher education for women. They wanted their daughters to go to university or work and to not get married at a young age as they had done. All six of them identified themselves as Muslim rather than Bangladeshi and all were also fluent in English.

The second group consisted of second generation Bangladeshis, who did not chew paan. They were working in Tower Hamlets on various health projects and used to meet on a monthly basis for support and peer review of case work. Health professionals and teachers are invited as speakers on specific issues related to health and community. They spoke English fluently as they had grown up in Tower Hamlets and gone through the British education system. Three of them were graduates and the other three were undergraduates. The aim in attending these two groups was to explore their

attitudes towards paan use. This was part of the sampling strategy in which the understanding of paan use between two specific groups were taken in to account.

Another group I observed was held in a community centre and it was a health promotion session. In agreement with the facilitators, arrangements were made to run an awareness session on paan use. A colleague conducted the session while I was an observer. The participants were eight women between 28 and 50 years of age, who had been born in Sylhet and had migrated after marriage. Seven of them chewed paan constantly and one claimed her use to be occasional, depending on her situation. Focus group participants are generally encouraged to behave in an informal and naturalistic way relating personal experiences, agreeing and disagreeing, arguing and accepting, interrupting as well as contradicting, while staying focused on the task and topic. To accomplish this balance an interview guide (Morgan and Krueger, 1998) was prepared. The interview guide strategies assisted group members to relax, open up, think deeply and consider alternatives and different opinions in order to elicit information that paints a portrait of 'combined local perspectives' (Duncan and Marotz-Barden, 1999). It was necessary to work closely with the group facilitator; a qualified moderator who encouraged the conversation, kept it on track and made sure participant engagement would be fair without some individuals dominating the group. Copies of the contents of flip chart notes were collected at the end of the sessions.

Being an observer enabled me to capture the way the participants interacted with each other, their sentiments on the topic and the ways in which they

voiced their views. It was also possible to watch the “silence” (Schensul and LeCompte, 1999) in some areas of discussions. The group discussions raised some important issues such as substituting tobacco paste for the tobacco leaf in the betel quid, buying ingredients of paan at wholesale price and new paan shops selling different varieties of paan products. These issues were incorporated into the questions prepared for the in-depth interviewing, the second stage of data gathering.

Phase two: In-depth interviews

As a longstanding professional with established social networks within Tower Hamlets recruitment of participants for the study was certainly facilitated. The recruitment was easier than expected mainly because the topic of paan chewing seemed an interesting subject among the study population. Hence it became easier to explain and clarify the objectives and the process of research.

Constructing a sampling strategy

Given that 95% of Bangladeshis in Britain come from the Sylhet district, it is unsurprising that the pilot research sample happened to be Bangladeshi women originating from Sylhet. While the small samples associated with qualitative research cannot be representative more generally it was crucial to collect data which sheds light on and deepens knowledge and understanding of human experience through exploring particular cases, and elucidating themes from them (Ely, 2001; Lincoln and Guba, 1985). Hence, a purposive

sampling strategy (Creswell, 1998; Miles and Huberman, 1994) was used as the selection procedure for the interviews.

A purposive sample is a non-representative subset of some larger population, and is constructed to serve a very specific need or purpose of a specific group. As Denzin and Lincoln (2000: 370) pointed out, researchers seek out groups, settings and individuals where the phenomena being studied are most likely to occur. Epidemiological research had already established that older Bangladeshi women were much more likely to be dependent paan users than younger women or men, and this had been supported by the focus group data. Hence, there are several reasons for selecting women in this age range. Firstly, the previous researchers (Pearson et al, 2001; Croucher et al, 2003b) on tobacco use have identified the health risks related to women of this age range. A study by Guha et al (2014), a random-effects meta-analysis of 50 publications assessing the relationship between oral/oropharyngeal cancer and chewing betel quid, demonstrated that betel quid chewing, with or without added tobacco, increases the risk of oral/oropharyngeal cancer in an exposure-dependent manner, independently of tobacco and alcohol use. Hence, these women are at risk due to their long exposure to chewing tobacco (Reddy et al, 1980). Secondly, it was possible to notice the signs of paan chewing among women of this age range; hence the research sought those in this age group who were using paan on a daily basis, women with visual signs of paan use i.e. the stained mouth, teeth and lips that are evidence of intense paan use. This indicates a long period of persistent use of paan, which has not been considered as a health risk or, even if it is of concern, the nature of dependence is such that health risks are often being

overlooked. Thirdly, they are the first generation of Bangladeshi women who migrated to England and a population under researched in terms of health risks and tobacco use; furthermore, the practice under investigation has particular social and cultural significance for older women who have followed this particular life trajectory. The women in the sample were also chosen because they had good skills in spoken English.

The purposive selection of 30 women with English language skills had two reasons. Firstly, as Loring (2002) pointed out, conducting research in two languages presents only half the challenge and after completing the research, practitioners need to find the most efficient method for analysing and reporting the findings, often in two languages (Loring, 2002). The pilot study also highlighted that Bangladeshi women of this age group had lived in Tower Hamlets for over 30 years and some of them had good English language skills. However, it should be noted that not all older Bangladeshi women are able to speak in English in the way the study sample did.

Older Bangladeshi women are perceived as a vulnerable group of people (Flora et al, 2012) and yet their tobacco use has not attracted much attention from the public health sector. It has been recommended (Muttagi et al, 2012: 32-35) that wide spread health education programmes are necessary to educate and motivate populations against the habit of chewing areca nut. Besides, while delivering various health promotion projects as well as during the fieldwork, it became clear that there is a need to work with this group of Bangladeshi women. It is therefore necessary to raise awareness among the study population as well as within the health professionals in order to avoid

further damage to the health of this group of first generation Bangladeshi women in Britain. However, this may raise the question as to whether paan use among second and third generation women of Bangladeshi origin should be overlooked. In comparison with the population under study, paan use among the younger generation is rare and only a few studies (Farrand et al, 2001; Nunez de la Mora et al, 2007; Longman et al, 2010) have been conducted to date; the contradictory nature of the findings of these studies was discussed earlier, in the chapter related to the background to the study. Nevertheless, focusing on these groups, older and younger, who are vulnerable to paan use can contribute to immigrant health research in terms of offering an improved understanding of population health patterns.

Researchers, who work with 'hard to reach groups' often employ a combination of methods to recruit participants (MacDougall and Fudge, 2001). For example, Jamieson (2000), in her study with young men and crime in Scotland, initially used the electoral register. When she found that this method alone was not adequate to complete her target sample, she used a multiple approach including leafleting homes, local organisations and community groups and even offering young men a modest financial incentive to participate in the study. However, payments for participants particularly in disadvantaged locations may attract 'ineligible' individuals who may create unanticipated problems (Lee, 1995: 41). In this study a more personal approach was used taking advantage of personal networks within the community in Tower Hamlets. In her research with Latino women, Madriz (1998), recruited participants by applying a more personal approach using personal networks such as community leaders, students and other

acquaintances who work for community organisations. Similarly this study used a combination of such methods in order to recruit participants and care was taken in order to select individuals who did not know each other. However, it should be noted that although this kind of sampling strategy is appropriate for exploratory research there are limitations to this kind of approach. For example the results cannot be generalised for a wider population.

The respondents in this study have been living in East London for over 30 years. Twenty-nine of them were born and had lived in Sylhet prior to their arrival in London. One respondent was born in Assam but moved to Sylhet as a child with her parents. Their age at the time of their marriage ranged from 16 to 20 years. The number of children they had varied from 4 to 8 and the age of the children ranged between 15 to 47 years.

In-depth interviews

When exploring the experiences of a vulnerable group, in depth interviews are an appropriate methodological approach. The purpose of the qualitative research interview is to obtain descriptions of the lived world of the interviewees with respect to interpretations of the meaning of the described phenomena (Kvale, 1996: 30). It necessitates 'active asking and listening' and the process involves a meaning-making effort which is started out as a partnership between the researchers and their participants (Liamputtong, 2007: 96). Therefore, in-depth interviews are also known as intensive interviews (Hesse-Biber and Leavy, 2005: 119). The strengths of in-depth

interviews are many. They allow probing and posing of follow-up questions in order to obtain good insights into the participants' way of thinking. Hence, they provide space for respondents to articulate their meanings in detail in order to make the researcher understand their view of the world more comprehensively. This helps in clarifying and confirming the participants' answers to particular questions. Since paan use is not commonly known, this is important to capture details that might be missed by clumsy questions. In-depth interviews are often used in sensitive research with vulnerable participants such as patients, elderly people, women and victims of domestic violence (Davis, 2002). Although the women in this research are not vulnerable in a straightforward sense, they have been marginalised and are unused to their experience being thought of as valuable by anyone outside their immediate family. Hence it is important to research issues relate to this group of women, while avoiding stereotyping and being aware of the structural constraints that impact on their lives. As Hesse-Biber et al (2004: 16) contend, often the lives and experiences of vulnerable people provide significant insight and perspective and complex human relations can become visible when research is started at the bottom of the social hierarchy.

Interviews collect verbal accounts of behaviour, meanings, attitudes and feelings that are never directly observed in the face-to-face encounter of the interview. This means that interviewing is based on two assumptions that are critical to the technique, namely those respondents' verbal descriptions are a reliable indicator of their behaviour, meanings, attitudes and feelings, and that the stimuli (the questions) are a reliable indicator of the subject of the research (Brewer, 2000: 63). The flexible nature of this kind of interview

enables the researcher to get as much detail as possible to achieve good data.

However, there are some limitations too. First of all, it is expensive and time consuming. There is also the tendency for the participants to show what is socially acceptable. As Brewer (2000: 65) pointed out, people may lie or can be inconsistent by not doing what they say they do; they can seek 'social approval' and say things in interviews that are socially accepted and approved rather than what they actually believe, feel or do. There are ambiguities related to paan - the fact that in some settings such as in Ayurvedic medicine both betel leaf and areca nut are used for therapeutic values and in others such as in medical discourses paan is treated as a health risk. Furthermore, paan is also considered as an acceptable stimulant but also chewing paan is seen as a backward social trait. Therefore it was very important to make women as comfortable as possible discussing their own paan use; to be non-judgemental and neutral. Untrained interviewers may distort the data unconsciously due to personal biases and poor interviewing skills. However, with well-constructed and tested interview protocols, higher reliability and validity can be achieved. In-depth interviews have been used by other researchers in order to explore sensitive issues as well as health-related issues. For example, as discussed in chapter two, using in-depth interviews Leipert and Reutter (2005) were able to elicit information on how women in geographically isolated settings are vulnerable to health risks as a result of their marginalisation. Their marginalisation was also the result of the physical, socio-cultural, political and historical circumstances. Furthermore, the authors contended that in-depth interviews assisted them to illuminate understanding

of the vulnerability of these women and observe the ways the women established ‘resilience’ in order to maintain their health.

The interview process

The emphasis on this phase was to provide a forum for women to talk and express their experiences of paan consumption and also their views, opinions, feelings, emotions, frustrations, aspirations and understanding related to their life in Tower Hamlets. Paan experiences were the main focus of these discussions. Pilot testing of the questions were carried out beforehand to avoid any ambiguous questions.

According to the preferences of participants, interviews were held in homes and in community centres. As discussed before, all interviews were conducted in English. They were semi-structured in that a list of questions was used as an interview guide. The open nature of the questions, however, encouraged participants to describe their understanding and feelings as well as views related to the topic of the questions. Each interview lasted between 45 to 60 minutes. Twenty eight interviews were recorded and two were written as per the participants’ request. The written interviews lasted more than 60 minutes.

Visiting homes was seen as a mark of respect for both parties. It was a privilege to enjoy the hospitality and openness of the women who showed their photographs from Bangladesh and some artefacts that were relevant as well as irrelevant to the study. An interview guide was used in order to keep focused. Questions were based on women’s experiences and several independent community leaders were consulted about the suitability of the

questions in terms of ethical and moral grounds. It was agreed with the interviewees that if they found any questions offensive or unsuitable, they were free to say that the question is inappropriate.

It has been pointed out by Kvale (1996: 20) that there can be an asymmetry of power in a professional interview; other researchers (Gunaratnam, 2003) have emphasised the multilayered and dynamic nature of power in research interviews. In order to equalise power relations the interviewees were treated and informed as the experts of the topic and a trusting relationship was established between the two parties. Asking ethically or morally sensitive questions in this way, allows the interviewee to discuss their position and experiences, without necessarily having to divulge their own practice (Mason, 2002).

This phase also sought to further explore and clarify issues identified during the fieldwork. For example, it was possible to talk about the pre-packed paan products which were collected from Bangladeshi shops. Furthermore, it became easier to explore respondents' understanding about new 'Bangla town' and other areas of interest, to see a vivid and comprehensive picture of connections and relationships Bangladeshi women see between particular events, paan habit and beliefs. In order to achieve this, interviewing techniques were tailored to elicit Bangladeshi women's descriptions of specific situations and action sequences related to experiences of paan, expressed in normal language. The specificity was important in that no general opinions were sought. There were no leading questions asked during the interview. However, when the term addiction was mentioned, it was necessary to clarify

what exactly they understood by the term because a researcher needs to be aware and conscious of the fact that words can have multiple meanings, especially so when English was only a second language for the research subjects. Corbin and Strauss (2007) commented that there is also the additional problem of accepting one's own interpretation of what is being said, that is, assigning a meaning without careful exploration of all possible meanings. Often, the interviewees used the term 'nice' to indicate positivity about a thing or feeling. 'Paan is very nice' was a popular sentence used by almost all the subjects and much time was spent during the interview probing what they really meant by describing it thus. The meanings they assigned were numerous – such as happy, tasty, good, nice mood, feeling good and sweet – all of which conveyed positive feelings and memories related to paan. Clarifying the meanings of their words was crucial in terms of analysing the narrative data collected during the in-depth interviews.

Data Analysis

The nature of the current study is such that it created a substantial amount of different types of data through fieldwork, interviews and literature from medical, social and anthropological origins. Due to the paucity of literature related directly to Bangladeshi women's perspectives of paan use, much information about the cultural and social significance of paan was retrieved through oral histories, community newspapers and magazines. Some authors (Glaser and Strauss, 1967) recommend the creative use of various types of written sources; such data was collected in this study to gain a

comprehensive understanding of the social role of paan. Some sources, as mentioned in earlier chapters, are of a historical and religious nature. There seems to be no definitive way of handling or approaching the task of analysing qualitative data (Bryman and Burges, 1994; Coffey and Atkinson, 1996; Robson, 1993**).** However, grounded theory principles (Glaser and Strauss, 1967) were used in analysing data to identify emerging themes. Themes come from various sources such as the literature review, field work and interviews. They also come from already agreed-upon professional definitions, from local common sense constructs and from researchers' values, theoretical orientation, and personal experience with the subject matter (Strauss, 1987). Due to the diverse nature of the data, the process of analysis in the current study was not a clear cut step, but taken concurrently along with the data collection.

Patton (1987) pointed out that when analysing data, the researcher has to be selective in choosing a method that will be appropriate for organising the data in a way that will lead to making sense of and explaining the phenomenon under observation. As Silverman (2005) suggested, analysis commenced with the data available in the public sphere. Using word-based techniques, it was possible to observe word repetitions, key-indigenous terms and key-words in the available complex literature. This provided not only a marvellous opportunity to refine methods, but also gave the opportunity for 'hands on analysis' (2005; 151) at the very beginning of the study.

As Hammersley and Atkinson (1995) recommended, the initial or tentative analysis of the data, guided the data collection further. However, I was aware

of the fact that relying and accepting initial hunches at face value can bias additional collection of data (Patton, 1987). Some of the emergent ideas fitted into many categories and often alternative explanations were sought throughout the data collection and analysis stages. The decision of what to observe or to describe is a deliberate and conscious action on the part of the researcher that may lead to difficulties in achieving objectivity and neutrality (Eisner, 1991). Seale (1999) made the point that all observations are driven by pre-existing theories or values which determine both how objects are constituted in sense experience and why some objects are selected rather than others. Throughout the data collection and analysis, I tried to be self-critical and reflexive in order to remain objective and neutral.

After the initial analysis of the data existent in the public sphere, fieldwork notes and the in-depth interview transcripts, were analysed respectively first using the same technique to identify recurring words and indigenous terms and then moved on to look for key phrases. Reflective memos were re-examined in order to further support the categorisation of emerging ideas and patterns and data was analysed manually. As referred by Okely (1994: 32), using the material to think with, allowed for hunches to be accepted or dismissed. Okely also argued that computer software would not be able to capture the essence of what had been observed. This was clear at the very beginning of the pilot stage when a computer assisted programme was tried in order to speed up the pilot, however, the narratives were extremely descriptive and covered several different areas of concepts, categories and themes which created a rich text that was not transferable to a computer programme that would bring out the essence of the narratives.

Transcripts were very closely examined and indexed, paying close attention to the content of the talk. As Coffey and Atkinson (1996) recommended, data was approached in a way that would identify themes reflective of the informants' views closely. The examples of Strauss (1987) were followed by making a distinction between sociologically constructed codes and Nvivo codes. These were used to develop a 'bottom up' approach in order to derive categories from the content of data (Coffey and Atkinson, 1996). These categories were re-examined in order to identify sub themes and finally to arrive at major themes. In this process, quotes that seem important were highlighted in different colours and later cut out and pasted on index cards which also recorded the context in which they occurred. Rainbow colours were used and each colour had three shades of light, medium and dark representing the intensity or the strength of the statement. When a category appeared strong it was placed in the dark group and so on. At times a statement could go under more than one category. It could be highly subjective, however, the aim was to make sense of the subjective data by looking at the 'recurrent preoccupations' (Coffey and Atkinson, 1996: 42) of the interviewees.

After the analysis of the first sixteen interviews, there was a feeling of disappointment as there were no new themes or sub themes identified. Grounded theorists refer to the point at which no new themes are being identified as theoretical saturation (Strauss and Corbin, 1990:188). However, the analysis was continued in order to avoid 'premature closure' (Wilson and Hutchinson, 1990: 123), where the researcher fails to move beyond the face value of the content in the narrative. Although no new themes emerged,

analysing the rest of the interview verbatim, confirmed the strength of the identified themes. As Strauss and Quinn (1997) have suggested, transcripts were also searched to identify metaphors and analogies used by research participants. For example, during the field work it was noticed that the term 'small Sylhet' was used to refer to Tower Hamlets. It was possible to identify similar patterns of speech and the repetition of phrases that indicated use of metaphors and the commonalities in participants' reasoning about use of paan as well as of life in Tower Hamlets.

Employing a bottom up approach it was possible to narrow down the themes and develop them into four main areas of concern: dependence, social role encouraged by cultural acceptance, lack of opportunities for wider social involvement and 'Sylhetisation', a term coined to encapsulate the features of creating and living 'Sylhet' within Tower Hamlet. This will be discussed in the next chapter.

Reflections: methodological lessons learned

It has been stated that in feminist research, the methodology must provide a way in which the researchers can include their own experiences, both as women and researchers, in the conduct of their research and in the sharing of their subjectivities with their research participants (Moran-Ellis, 1996: 177). Therefore, feminist research is described as 'consciously reflexive' (Allen and Walker, 1992: 202). Similarly, in ethnography, rather than trying to eliminate the effects of the researcher, ethnographers should be reflexive (Hammersley

and Atkinson, 1983: 17; Altheide and Johnson, 1998: 297). In this research although there are some aspects I share with the participants there were differences between the researcher and the researched as well. Therefore as Keval (2009: 52) points out, “the overt and explicit acknowledgement of researcher biography connecting with aspects of the participant identity facilitates a need for reflexive qualitative methodology”.

Denscombe (2007: 333) says that the legacy of values, norms and concepts we have assimilated during a lifetime, differ from person to person and culture to culture. These differences matter; as mentioned earlier in ethnographic studies, the researcher becomes the research instrument and this can affect the way the data is collected, analysed and interpreted, influencing the understanding of the research outcomes. Therefore, the researcher is an integral part of the research process and greatly ‘contributes to the construction of meaning’ during the study (Gilbert, 2008: 512). This makes it imperative for researchers to acknowledge their own influence on the study and offer transparency to the research process. Within postmodern research, there is a strong emphasis on self-disclosure (Grbich, 2004); this is visible with some feminist research too. As (Gilbert, 2008: 512) states, reflexivity can be described as a ‘style of research that makes clear the researcher’s own beliefs and objectives’ and in completing this study I have tried to be reflexive from the very beginning.

Coffey and Atkinson (1996) pointed out that an active and analysis-orientated approach to the literature is an important part of the recurrent process of reflection and interpretation. From the very beginning of the study, it became

apparent that there was a considerable academic divide between the scientific and social research related to paan and its components. They were like two parallel lines that would not meet; hence, the motivation to incorporate both fields in my study. Although it was a laborious process to read almost all the literature written on paan available, in hindsight it was too ambitious a task. Nevertheless, the time spent was productive in terms of developing a comprehensive knowledge of the topic under investigation through multidisciplinary sources of documentation.

During this study there was an opportunity to work with people from different social and academic backgrounds, sometimes more as an insider and on other occasions more as an outsider. Whatever the circumstances, there were reservations and assumptions about the research process that created anxiety. For example prior to phase 2 of this research, there was anxiety and concern about the in-depth interviews. Some of the anxieties were based on fears of the unknown. The following are the questions that created anxiety.

- Are the respondents telling only part of their experiences?
- Do they see the researcher as a health professional or someone from the education authority?
- Are they subjective in their accounts of hardships of immigration?
- Are they expecting the researcher to help them quit paan?
- How to respond if they ask for help and how ethical it would be to help or ignore?

Despite these anxieties, maintaining the fieldwork diaries had a therapeutic effect. Looking back on each day, gave a sense of contentment from what had been achieved on that day and it also encouraged preparing for the subsequent day. Organising different methods and attending a number of social and cultural events, being unable to say 'no' for the fear of missing something very important, preoccupied the thoughts during the first two years of the research. However, it helped to compare the different kinds of data gathered and the different methods used to see whether they corroborated one another, a form of methodological triangulation (Mason, 1996: 25).

Bryman pointed out that researchers should be reflective about the implications of their methods, values, biases and decisions for the knowledge of the social world they generate (2001: 471). This has been observed by being conscious of these obligations and reflective throughout the research activities and while presenting the findings. Wherever possible, personal feelings and understanding about the research process have been noted in the thesis. In her research into sexual violence, Stanko (1997) used reflexivity to disclose her feelings about her experiences of managing anger, pain, fear and frustration during the research process. In addition, as cited in Liamputtong (2007), Elizabeth Stanco used reflexivity to tell readers about her political attempts as an academic activist and her personal struggle for coming to terms with her beliefs and hard facts. While there were no comparable traumatic conflicts involved here in the current study, it was necessary to be aware of how both the similarities in experience (as an older Asian woman who has come to the UK and raised a family here) and the differences (in education, background and material position) might influence

this research in terms of invoking sociological contexts in health and ethnicity and highlighting inequalities related to paan use among Bangladeshi women.

Bangladeshi women's paan use cannot be seen as a general social class inequality or as a product of cultural difference. As Kelleher and Islam (1996) pointed out researching cultural differences in health can obscure the impact of racism upon the health of minority communities and the health services available to them. Engaging with people whose personal experience covers such complex biographical journeys, whose lives established successfully through facing challenges of racism and material marginalisation has both personal and political dimensions. Hence, making visible ignored experience is a large responsibility. Despite the use of several methods, it is unlikely that all the relevant aspects of social processes were captured. Nevertheless as Strauss and Corbin (1998a: 295) state:

> Sometimes, one has to use common sense and not get caught up in worrying about what is the right or wrong way. The important thing is to trust oneself and the process. Students should stay within the general guidelines … and use the procedures and techniques flexibly according to their abilities and the realities of their studies.

Conclusion

By moving away from the familiar scientific research into a totally new area of ethnographic adventure, this study posed a number of hurdles. Each hurdle gave a new set of challenges. Tackling these challenges gave fresh

confidence and a deep understanding of the suitability of the methods used. As the research progressed it became clear that the research methodology of a multi method approach did not have a neat transition from one to the other. Instead, to borrow from Brewer's (2000) description, it was a messy interaction between the research problem, the design of the research, data collection and analysis. Each step and method generated a different type of information contributing to a broader meaningful picture which will be described in the following chapters.

CHAPTER 4: TOWER HAMLETS, SYLHET AND BANGLADESHI WOMEN

Introduction

This chapter is about the study population and their present and past places of residence. Tower Hamlets, is home to the majority of Bangladeshis living in England. The environment plays a crucial role in people's health and illness. Weiss (2001) argues that in-depth explorations of the health and illness of a group, should set their experiences into context. The life experiences of the study sample, reflect their history of migration, cultural change and the creation of a specific cultural context within their chief area of residence, Tower Hamlets, since leaving Sylhet.

Having migrated from Sylhet, Bangladeshi women in the present study have lived in the London Borough of Tower Hamlets (LBTH) for over 35 years. They have lived for a longer time in Tower Hamlets than in Sylhet. During this period, according to their own stories, they have experienced; poverty, racism, loneliness and loss, as well as a sense of satisfaction from their achievements and successes while settling and making a new home in Tower Hamlets. Since arriving in East London, their circumstances have changed dramatically. Having moved to a land both far away and very different from their original homeland of Sylhet, they have learned to live in a totally new environment and climate and they become bi-lingual. The presence of Bangladeshi community, has brought about noticeable changes in the borough of Tower Hamlets; it is therefore, necessary to understand this symbiotic relationship in order to place the subjects of the current study in their present context. The first and

the second parts of this chapter will focus on Tower Hamlets and the Sylhet region from where the majority of Bangladeshis in the UK have originated (Home Affairs Committee report, 1986). An introduction to Tower Hamlets includes a short description of its location, demography and the history of racism that Bangladeshi people remembered. The second part of the chapter will describe Sylhet in terms of its geographical situation, migration and the way Bangladeshi people recall their villages. Bangladeshi women will be the focus of the third part of this chapter. In addition to the findings of the previous studies, field work observations and narratives from the fieldwork visits and interviews are used to highlight the relevant points made by other stakeholders.

Tower Hamlets: Home for the Bangladeshi women

Situated in the north of the Thames river and covering much of London's traditional East End, the LBTH was recently one of the five host boroughs for the 2012 Olympic and Paralympics games. Tower Hamlets has undergone major developmental changes of a positive nature. Several of the modern landmarks such as Canary Wharf and other tall buildings in the Docklands area, are located in Tower Hamlets.

Bangladeshis form the largest ethnic minority group in the borough. The first thing a visitor entering Tower Hamlets might see and feel, is the presence of the Bangladeshi community in this part of London. According to the Office for National Statistics (ONS, 2006), 56% of the population of Tower Hamlets belongs to an ethnic group other than White British. The existence of

Bangladeshis with a residential population of 30% (ONS, 2011), has shaped the demography of the borough as it appears today. For example, Bangladeshi-owned restaurants, factories and other commercial enterprises are abundant in Tower Hamlets. Commodities from Bangladesh are available in shops and hospitals in the borough are signposted in the Bengali language, a unique feature that cannot be seen in any other area of multi-ethnic and multicultural London. The Sylheti language is spoken by Bangladeshis here and the majority of Sylhetis identify themselves as Sunni Muslims. During prayer times, men of all ages attend one of the local mosques – one situated on the busy Whitechapel Road and the other in Brick Lane. Bangladeshi men and women are visible on the streets as well as in shops as they go about attending to their daily routines such as shopping, accompanying their children to and from school and on other journeys.

Although life in the East End has changed gradually over the past few centuries and rapidly in the last three decades, there are similarities between the experiences of early immigrants of Irish and Jewish origins and those of the contemporary Bangladeshi British population. In order to highlight the kinds of hardships that Bangladeshis have faced in the process of their settlement, it is pertinent to examine the historical aspects of immigration related to Tower Hamlets. This is important in terms of contextualising the present Bangladeshi population in their locality, the borough of Tower Hamlets and in the East End.

Over the past few decades, social and anthropological researchers (Samuel, 1989; Palmer, 1989) have published a substantial amount of literature on

various aspects of migrant histories related to Tower Hamlets (see also Eade, 1994; Abbas, 2005 and Garbin, 2008). In order to place the study sample in their present context, it is necessary to examine their life experiences in terms of stresses and tensions related to their environment, which may have relevance to this research.

A brief history of racism and intolerance

Scholars researching race (Gunaratnam, 2003; Bulmer and Solomos, 2004) have highlighted the importance of understanding the impact of racism on lives. Attention has been given to exploring the emotional dimensions of racialized life by several researchers (Gunaratnam and Lewis, 2001). Traditionally, East London has become the home for many immigrant communities over several centuries. Ever since the arrival of French Huguenots in the latter part of the seventeenth century, there have been groups of people moving into the East End of London. Some, such as the Irish and the Bangladeshis, arrived looking for work, while the Huguenots and the Jews came to escape religious persecution and discrimination (Gavron, 1997). Regarding Bangladeshi immigrants, their purpose of arrival in Britain initially was and still remains economic. Their main aim was to earn a substantial amount of money for investing in land and property in Bangladesh and to then return to their motherland (Gardener and Shukur, 1994: 142 – 147). The local residents or indigenous population also believed and expected the same from them. Abbas (2005: 9) has argued that this is also one reason for the limited acceptance of immigrants by the white working class

indigenous communities. This local or host population, expected the ethnic minorities to return to their countries of origin after they had earned and completed a period of employment in the UK.

The East End of London has a history of racial tensions and antagonisms. Thus, Tower Hamlets is seen to have experienced different degrees of racial violence even before the 1930s when Oswald Mosley incited attacks on the older Jewish community (Gardener, 1990). It is in fact evident that with the arrival of every immigrant community, racism and intolerance within the indigenous or host community, led to hostility towards the newcomers. Ranger (1996: 7) has pointed out that post-war immigrants, Asians and West Indians were subjected to the same treatment as the Irish Catholics, who had migrated to the East End in the eighteenth and nineteenth centuries. Rennie (2011) pointed out that in the early 1700s, London apprentices took to the streets of Spitalfield, attacking immigrant Huguenot silk weavers. In 1736, there were riots against Irish immigrants who were seen by the local people as too eager to work and to be displacing the English workers (Palmer, 1989: 18). Referring to these incidents, Gavron writes:

> This is an early example of a widespread hostility towards immigrants which has consistently employed two contradictory stereotypes: the canny and self-seeking worker who, by his eagerness to find employment at any price, will lower the market value of the labour of other workers, and the feckless indolent leech who arrives with an outstretched hand and a posse of dependants. Both these stereotypes have been exploited by the extremists at various times, who have

> wished to encourage xenophobia against immigrants in recent centuries (Gavron, 1997: 24).

The antipathy of the locals towards the outsiders or the 'others', is complex combining economic reasons, actual or imagined, with cultural factors. Thus, for instance, Irish immigrants were hated by the local residents due to their different religion, rather than on grounds of race (Samuel, 1989). Bangladeshis, on the other hand, were not only followers of a totally different religion in the eyes of the local people, but spoke a different language too, were physically different in appearance and also easily recognisable or distinguishable. As Ballard (1994: 2-3) argues, skin colour serves as an inescapable social marker. The effects of racism are also complex, racism varies in intensity and along a wide spectrum from everyday discrimination to terrible acts such as murder. The period when these women first arrived was marked by very visible conflict and even violence.

As the majority of participants and community leaders remembered, on 4th May 1978, Altab Ali, a Bangladeshi youth, was murdered on the streets of Whitechapel by a gang of white youth because of this social marker (skin colour). The death of Altab Ali was a result of the growing hatred towards people of colour. It has been reported that during this period, the British National Party (BNP) and the National Front (NF) were organising violent attacks against Bangladeshis and slogans such as 'Blacks Out' and 'White is Right' were used against the Bangladeshis (Power, 1979). Some of the respondents recalled the time when Tower Hamlets council had fitted flats with fire-proof letterboxes to protect Bangladeshi tenants from racially

motivated arson. Bangladeshis were, therefore, extremely scared and Bangladeshi mothers organised themselves into groups to take their children in and out of schools safely. Bangladeshi people remember the incidents vividly and one of them Zaira, a 61 year old woman recalled the fellow feeling within the Bangladeshi community:

> My boy was not going to school that time ... he is born in ’78 ... but my neighbour had three children and I also helped to go to school to bring children. When I go I keep baby with Nazeema … I like to do that because I met other women and then I have more friends. I thought if I help them, they will help my boy one day

The accounts of Zaira and other respondents reveal that the life of Bangladeshis in Tower Hamlets had been dangerous and difficult until the 1990s. The BNP was active in the Brick Lane area and there were organised racial attacks. In September 1993, BNP members went on a rampage down Brick Lane. They smashed the windows of shops and restaurants, injuring several people. A week later, Derek Beackon, won the BNP’s first ever council seat – in the Isle of Dogs (Cook and Stevenson, 2000). In response, Bangladeshi youth, along with some of the local people of Tower Hamlets, had organised themselves to resist violence. The day after the BNP won, an anti-racist protest strike was held by the local council workers. The anti-racist struggle continued for years and at the end, in April 2001, the local council officially recognised and renamed the Spitalfields electoral ward as Spitalfields and Banglatown. Although the environment has improved since then much to the satisfaction of local Bangladeshis, there is still resentment

towards immigrants, though to a much lesser degree. Nevertheless the respondents were much less anxious today about racism.

The negative perceptions about Bangladeshis is still prevalent in sections of local residents of Tower Hamlets. A local resident, Mr. R, whom I met during the fieldwork, had no hesitation in describing Bangladeshis in derogatory terms.

> Never have they [Bangladeshis] done a day's work in their life – real scavengers. Producing children like rats and getting all the benefits, shameless ... the council gives them everything. Look at all the new flats, we can't have them. They are built for them ... They are the priority. …

Another indigenous resident Mr. J was unhappy about the local council's housing allocation to its Bangladeshi residents:

> They will take any job with a lower pay ... they take our jobs. It suits them because they send money abroad and get more value ... They will come here with a big family ... so many children and claim all the benefits. We have to live in the same old houses and as soon as they are here, they get new flats and houses allocated to them.

Mr. H introduced himself to me as 'an 85 year old cockney'. He has lived in a two bedroom flat for the last 25 years and all his friends have by now either moved out of the area or have passed away. He is a loner and the old community in which he once lived, has dispersed. He presently only knows his neighbours who are of Bangladeshi origin. Although he said that he does

not mind Bangladeshi food, his negative perception was evident in what he said:

> I don't mind their [Bangladeshi] food. What else can you get in this area, anyway? Look at Brick Lane. They have opened shops everywhere. They are open till late night and they don't sleep. I suppose it's not their fault. This country allows these people to come and the Council gives brand new flats and houses, so why should they go back?

It should be noted that there is a huge variety of responses and not all are negative, nevertheless, it is certainly not the case that all xenophobic feeling had gone. Sentiments among local residents that the local authority had ignored the indigenous people whilst giving priority to the welfare of immigrants are widely shared. During the field work, there were many similar remarks expressed by residents. It is interesting to note that this kind of blaming is also not a new phenomenon. When Boundary Estate, (presently occupied by Bangladeshis), was built in 1901 to replace the slum housing, it is reported that almost half the new tenements were allocated to Jewish immigrants, without giving priority to the indigenous working class people who lived in the slums (Samuel, 1989).

London's past urban development has also impacted on the East End and its residents. The clearing of slums and development of roads and railways in London and elsewhere, led to the eviction of those who lived in the area. They moved to East London in increasing numbers, along with those who came from Eastern Europe and Russia (Palmer, 1989). Docklands too attracted

people, and East London was always crowded and over-populated. Jewish immigrants from the 1860s and 1870s, found less trouble in finding work and housing than those who were later arrivals (Palmer, 1989). Similar to Jewish immigrants, Bangladeshi men went into work in the clothing sweatshops and other tailoring factories.

Despite the difficulties that Bangladeshis faced in settling down in the new country of their adoption, both the older community leaders and the younger people are very optimistic about their future in Tower Hamlets. A community leader commented that in the 1992 general election, the leader of the BNP was only able to achieve less than 1500 votes. This was an achievement for those who fought against BNP activities. Traditionally, East Enders have stood against racism. It was reported that when xenophobia was rising in the 1930s and especially in 1936, Jews and their property in Bethnal Green, Shoreditch and Stepney, were attacked on a regular basis (Husbands, 1982). However, even in the 1930s, at a time of economic depression when fascism was rising in Europe, the East Enders had remained calm and did not allow anti-Semitism to be aroused to real fury (Mandle, 1968). One of the residents gave her experience that not everybody was against Bangladeshis. She said:

> When I came here I used to go to my back garden and look around ... my next door lady if she is out, I smile, but she quickly go in and close the door, very loud you know. Like she saw a ‘bhoot’ [ghost] ... When I tell my husband, he tell why do you want to go out, just stay in. They don’t like us … but you know, the lady in the front always smile and wave when I open the door to take my milk in. Sometimes we open the

> door at the same time after the milkman came. I remember she always had a green apron ... Sweet old lady. I know lot of them are very good ... One or two only bad .. (Zara 62).

Another woman said that even the local children hated immigrants:

> Sometimes when the milkman comes his little son comes with him, like in the week end, one day I asked for bread and the little boy brought the bread from the cart and just threw it on the milk crate. He dint give it to me, as if he was angry. But his father was a kind man ... he will always tell 'O right?' This happen about 20 years ago, I never forget, sometime I wonder he must be ... I mean the child a big man now ... maybe he has changed and like the father not racist anymore

The participants believed that despite the racism they had seen, heard and experienced, not everybody was against them and Tower Hamlets is a good place to live. As for the respondents, racism was a thing of the past and they are glad that circumstances are better now and they have survived the difficult times in Tower Hamlets. However, this thesis does not contend that racism is only a problem faced by the first generation of Bangladeshi people. Neither does it suggest that Tower Hamlets is a sterile, stress free environment; it has its own social and political problems. The study of Mumford and Power (2003) on roles of community and family life examined the notion of race within multi-ethnic neighbourhoods; researchers highlighted the culture and attitudes of racism that still exists among local White community. Tower Hamlets is a place of complex tensions and divisions, however, it is also a place where Bangladeshi migrants have been able to thrive. While the social and political

problems are common place in the inner cities, exploration of many of these issues is beyond the scope of this thesis. Nevertheless, issues related to the impact of racism on health (see Higginbottom, 2006; Karlsen and Nazroo 2002a and b) has already been raised in chapter two. Despite the potential problems, the East End has been and continues to be the 'transit lounge', as well as a stable dwelling for the Bangladeshi immigrants in their journey in search of a better future. As far as local businesses are concerned, the same kind of trading that existed in the past is still continuing along with new consumer goods that cater for the new population. Buildings once owned by Huguenot silk traders, are still selling silk, the difference being that now they belong to Bangladeshis and silk today is imported from India. There are still some Jewish establishments in the area. However, the majority of the trading is done by Bangladeshis from Bangladesh and Hindu Bengalis from India where local Bangladeshi women are employed to work in these shops.

The clothing factories in the area have been an important source of employment for Bangladeshi women as well as for Bangladeshi men. Bangladeshis now own some of the businesses previously established by Jewish immigrants. It has been reported that some of the first generation migrants have returned to Bangladesh where they have set themselves up as clothing manufacturers and exporters (Kabeer, 1994). They are in competition with the local-owned factories and have contributed to a weakening of the market for clothing produce in the East End (Rhodes and Nabi, 1992: 339). Globally, there has been an increase in women seeking work, and this is reflected in the experiences of Bangladeshi women, both in Asia and in the UK. Kabeer (1994: 168) has highlighted the fact that Bangladeshi women in

Dhaka, over-ride male objections to their working. As I will discuss in the findings, the study sample clearly indicated male support for women's education and employment.

As Gavron (1997: 173) contends:

> In Tower Hamlets, many women are perfectly capable of insisting on their right to seek paid work, despite the fact that parents in London believe that the persistent community disapproval of inappropriate work outside the home might damage their chances of arranging a suitable marriage for their daughters. As in Bangladesh, their attitude is gradually changing as more parents and husbands are recognising the importance of their daughters or wives as contributors to the family income, sometimes the only contributors.

In the past, the majority of the study sample (21/30) had worked from home, mainly as machinists for clothing factories in Tower Hamlets. However, currently, there seem to be problems in finding machinist work to be done from home. Shamzar a sixty year old woman showed her disappointment about lack of work:

> When I came in this country I was educated you know, I could do a good job, but because of children I could not go out, so I started as a machinist. They will bring home and give work, you have to only sew one thing, then they will take it to somebody else. I liked it and earned so much money and sent to my family ... but now ... no work I can still do. I am very quick, but no work like those days ...

It should be pointed out that the first generation of Bangladeshi women are now elderly and it is unlikely that Tower Hamlets can offer them employment. Nevertheless, their lives reflect not only the physical trajectory of migration, but changing cultural ideas of gender roles. Their own working lives stand testament to this, and the educational attainments and careers of their daughters also reflect their achievements. This echoes with the findings of other feminist researchers who have studied issues related to marginalised women. As discussed in chapter three, the findings of their study exploring how women in geographically isolated settings in northern Canada maintain their health, Leipert and Reutter (2005: 51) highlighted the way women use strategies of 'resilience' to overcome hardships. However, having placed the interviewees in their present context and understood the tensions and stresses as well as their ambitions, it is relevant to present a brief introduction of Sylhet, the birthplace of almost all of them and their childhood habitat.

Sylhet: The land of 'Londonis'

The name Sylhet can refer to the Sylhet division, the Sylhet district or the Sylhet town. Sylhet division, which is also known as Sylhet region or greater Sylhet, is located in the north-eastern part of Bangladesh. It is divided into four districts; Habiganj, Maulvibazaar, Sunamganj and Sylhet. In this thesis, the term Sylhet refers to the Sylhet region from where the respondents of the present study have originated. They spent their childhood and part of their adult life in the Sylhet region until they came to live in Britain. They have described Sylhet as the most picturesque place they have seen. It is indeed a

place with sceneries of hilly tea plantations and emerald green paddy fields. Sylhet division has over 150 tea estates that contribute to its economy. Bangladesh exports tea to Pakistan and Russia. The Surma valley is covered with tropical forest and tea plantation. Three of the largest tea estates in the world are situated in Sylhet. The beautiful Sylhet was once part of British India that has also witnessed a history of political and social upheaval.

When asked about Sylhet, the first interviewee's response was that it is the 'Londonis' place. That was her understanding and it is the way the people who have left to go to London are known in Sylhet. Another man explained that any family who sends a family member to London will be known as Londonis too. They will then send money home and if possible other family members will go to London to work or to get married to a relation who is already settled in England. There is a generalisation that 'Londonis' build big houses with modern facilities in Sylhet. This seems to be the ambition of many. In the past the first aim was to build a house of their own with modern facilities, so they sent money to the relatives who not only built a house, but sent more relatives who strengthened the social network. Migrants often have social and kin networks through which they establish further opportunities of migration for families and friends from their originating countries (Anwar, 1995). The networks utilized by migrants vary considerably depending on local histories of migration, national conditions and communal socio-cultural traits (Vertovec, 2002). As for the people from Sylhet their history including working in the British India Company and the effects of national disasters such as the war with Pakistan, have encouraged them to leave their birth

place in search of a better future in developed countries such as England and the United States.

During the British Raj, Sylhet had been made a part of Assam in 1874, but, when India became independent and was partitioned, Sylhet too was partitioned (Choudhury, 1994). Thus, after a referendum, some parts of Sylhet were handed over to the newly-created state of Pakistan and began to be known as East Bengal. This continued until 1971, when East Bengal broke free from Pakistan and became an independent country under the name of Bangladesh. This break in 1971 is grounded in the ethnic and linguistic differences between the people of the two areas and the discrimination and suppression of the Bengali language and culture by the Pakistani government. It fostered cultural nationalism amongst East Bengalis and eventually led to serious clashes between East Bengalis and the Pakistani government. As Choudhury explains, when the first democratic election was held in Pakistan, an East Bengali party won, but the Pakistan military, refused to honour the election results. As a result, protests broke out and Pakistan declared war against the East Bengali militants. After the intervention of the Indian army, Pakistan lost the war and Bangladesh became independent (Choudhury, 1994). This brief history is important to help understand the influences that shape Bangladeshi culture and economy.

Due to the history of Sylhet as well as its geographical location, the people of Sylhet have some ethnic traces that can be traced back to Assam, Bengal, Arabia, Persia and Turkey (Chakrabarti et al 1992). This is reflected in the Sylheti language, which is very distinctive in terms of its richness due to the

various linguistic influences that have impacted on it. It can be looked upon as a language related to the rural dialects of Eastern Bengal which has evolved and absorbed several words and features from other languages spoken in the borders of Bangladesh. This exclusiveness of the Sylheti dialect, has given the Sylheti people a regional identity. Some of the participants (18) of the study identified themselves as Sylhetis and others used both the terms 'Sylhetis' and 'Bangladeshis' while referring to themselves. Over 95% of British Bangladeshis originate from the Sylhet region (Begum and Eade, 2005).

After the 1971 war, many people from Sylhet came to England looking for employment opportunities. In much the same way that changes that took place as a result of the arrival of Bangladeshis in Tower Hamlets, Sylhet too has benefitted from the remittances and contributions made by Sylheti people living abroad. At present, there are investments and businesses in Sylhet city and in large towns funded by Sylhetis living abroad, in particular by British Bangladeshis; some shop keepers in Tower Hamlets own businesses in Sylhet. The respondents of the study were well-aware of the progress in Sylhet and its transition. The situation there is not what it was earlier, when the respondents had left for England. It is also different from the picture the respondents remember and they are aware of it. Salma, a woman from Sylhet who had lived in Tower Hamlets for 35 years said that the changes in Sylhet are unbelievable:

> I can't believe when I went there it is so different so many houses and big shops. All places I remember changed and I can't believe. But ... it

> is good people have money … they go shopping and you can buy anything.

Current day Sylhet is not just the land of ‘Londonis’, but a land of opportunities. People from Sylhet now travel to many countries and there is considerable material and cultural exchange between Sylhet and foreign lands.

Sylhet migrants then and now

Mr. M, one of the Bangladeshi residents from Whitechapel in East London, said that his great grand uncle worked for a British ship and never went back. According to him, his grand uncle was not poor, but he wanted to join his friends who were already working on British ships. The relationship between Sylhetis and Britain goes back as far as the latter part of the eighteenth century, when people from India were employed in the British Merchant Navy ships (Adams, 1987). Among them were the Sylheti workers who arrived in Britain as “lascars” working as the sailors employed in European ships. Due to the geographical location of Sylhet, villagers who knew about the job opportunities available in the ships, used to gather around the shipyards hoping to find work in ships. They were poorly paid as compared with their British counterparts. However, since the British industry depended on human resources from its colonies along with the other immigrants, Sylhetis sought work in ships and found their way to England (Gardner, 1990).

As Gardener explains, the British policies towards recruiting people from British colonies as a labour force outside their original homeland, impacted on Sylhetis. Thus, in 1946, when the British government started recruiting a labour force from the Commonwealth, more single men from Sylhet began to arrive in England (Adams, 1987; Cohen, 1987). They were entitled to work wherever they chose. Alternatively, they could find work through the labour office in industrial cities such as Bradford and Newcastle. These men were employed mainly in jobs which the local people refused to do. However, when compared with the limited opportunities their own countries offered, the British promise seemed lucrative to the Sylhetis and the other Commonwealth citizens. This was especially due to the fact that sometimes, the British government and other private employers paid the fares which they agreed to be deducted from their wages afterwards (Gardener, 1990).

The Sylhetis had some in-built advantages. They had the benefit of living close to the river Kusiyara and had access to boats and cargo ships that came from Calcutta (currently known as Kolkata). Compared to others, they also had more social networks because Sylhetis already had a history of being employed in England (Adams, 1987) and this helped the new arrivals in London to find jobs and boarding houses to stay in. There were agents who facilitated the migration from Sylhet to Britain (Gardener, 1990). The demand for British jobs grew higher so much so that a labour office was opened in Sylhet. Consequently, the number of ‘Londoni’ families along the river Kusiyara, increased with time. This explains the higher concentration of Sylhetis in London.

As Gardener (1990) pointed out, another reason for the early migration of Sylhetis to England was its affordability for them. The special status, in which Sylhet was placed, meant that Sylheti farmers remained independent cultivators rather than small tenant farmers characteristic of the rest of Bengal. They, therefore, enjoyed a higher economic and social status than many of their fellow Bengalis. Thus, Sylhetis not only had the economic means to migrate, but were also not keen to engage in manual labour for others, all of which combined to provide impetus to their migration (Gardener, 2002).

In the 1950s and 1960s, the academic debate on migration was focused not only on the effects of development on migration, but also on the reciprocal effects of migration on development, namely that the reduction of labour surpluses (and hence unemployment) in areas of origin and the inflow of capital through migrant remittances, could improve productivity and incomes (Massey et al, 1998: 223). This is true in the case of early immigrants from Sylhet and other Commonwealth countries who arrived in Britain without their families. Older Bangladeshi men who took part in informal interviews during the fieldwork, have sent a considerable amount of remittances to build houses in Sylhet, and are now in their late 60s and 70s. They showed willingness to return to Sylhet depending on one condition, their good health continued. Some of the spouses of the older female participants have already returned to Sylhet for their retirement. It was different for the women in this study however, as they did not show any enthusiasm to return to Sylhet except for holidays. According to the majority of the female study participants, they viewed their home as being in Tower Hamlets. However, gender

difference in migration today is very different. For example, global estimates by gender confirm that for more than 40 years since 1960, female migrants reached almost the same numbers as male migrants (ILO, 2003: 9). These women come from a wider background and find employment in labour markets as well as in professional environments.

Unlike those who arrived in the 1960s and 1970s, not all the present migrant women from Sylhet necessarily leave their home to join husbands. Some younger women have arrived as marriage partners, while others are here for further studies with the hope of settling down in the UK. Many of them arrive with a clear idea to work and stay, expecting to raise a family and educate their children. Under the student visa scheme, young people from Bangladesh enter British universities. Some of these students tend to find jobs at the end of their studies and eventually stay on in Britain. There are others who own enterprises in Tower Hamlets. The owners of these enterprises spend most of their time in Britain. It is also common knowledge that the universities of Bangladesh attract foreign students for medical education. Those who fail to secure places in British medical schools can apply for admission at universities in Bangladesh as private students. It is now possible for some Bangladeshi families to get their children educated in Bangladesh or in other private medical schools in European, Indian or Chinese cities as doctors.

Migrant remittances as regards Bangladeshis, have a multiple purpose now. In addition to building luxury houses, businesses have been established by the British expatriates in the city of Sylhet. Hotels and restaurants, often

themed on those found in London, have also been established to cater to the visiting Sylheti expatriate population and the growing Sylheti middle classes (Foster, 2006). This has been the case with the Bangladeshi diaspora whose members live in other countries such as America and other European countries. It has been argued that diasporic groups have been particularly adaptable to a globalised economic system (Cohen, 1997). The 2006 Global Economic Perspective Report published by the World Bank revealed that remittance by the migrant workers has helped Bangladesh to cut its poverty by 6% (Sylhet Urban Plan, 2010). Remittance has also accounted for nearly 35% of the country's export earnings. In spite of global recession, remittance inflows, which hit a record high in the year 2010, managed to maintain its growth. The following extract from the Report of Master Plan for Sylhet Divisional Town (2010: 4-6) describes the diasporic contribution to current Sylhet:

> The construction industry in Sylhet is currently booming with many shopping centers being built by expatriate Bangladeshis. London Mansion, Millennium Shopping City etc. were established to cater to the visiting Sylheti expatriate and the growing Sylheti middle classes. The economy of the city is showing an upward swing in general amid growing consumerism. In the early 80's, Sylhet had only a few shopping centres, but today it has considerable number of shopping malls and modern shopping centers to meet the changing demand of the consumers.

On the whole, there are much more exchanges taking place between Bangladesh/ Sylhet and Tower Hamlets in terms of people, kinship, materials, remittances, media and many other social aspects. As Anthias (2008) pointed out, when people construct themselves as a diaspora, a particular form of mobilisation around national and ethnic symbols which are used as resources comes into operation, and as a result, ethnic and cultural ties are increasingly operating at a transnational rather than merely a national level. Anthias also points out that diasporas should not be treated as unitary, that these groups are diverse and contain many important conflicts and inequalities. Gender roles have been transformed both in Bangladesh, and in the UK. Though the older women in this study appear to be much more traditional than the younger generation their role in creating homes, contributing to livelihoods and supporting their children should not be stereotyped, as discussed in the following chapters. Similar to the transition that Bangladeshi women have undergone, Sylhet has changed too. Their ethnic and cultural ties with Sylhet along with those of other Bangladeshi diaspora are instrumental in changing this socio-economic transition of present day Sylhet.

Bangladeshi women

Studies based on the Bangladeshi diaspora have highlighted that they are the poorest of all ethnic minorities (Kenway and Palmer, 2007). Documented evidence shows that around one third of Bangladeshi households are likely to live in officially recognised ‘non decent homes’ and nationally, the majority of households live in social sector rented accommodation (ONS, 2005). Economic and social deprivation is reflected in the health status of

Bangladeshis and they suffer from high rates of limiting long-standing illness and self-reported morbidity (Phillipson et al, 2004). However, they continue to remain an under-researched group.

A review of the literature by Phillipson et al (2004) revealed that there is only a limited number of studies on Bangladeshi women, with particular neglect of those in the middle years. They are women of the first generation who arrived here from Sylhet with their spouses during the recession of the 1970s and 1980s. Their daughters who were born in England, are the English-educated bilingual second generation. Then, there are the children who were sent to Bangladesh as infants and later rejoined the parents as teenagers. There are differences between these two groups of the younger generation, especially in relation to their outlook on life events. Along with the second generation, there is another group of young women who came as wives in their teens or early twenties and underwent the stressful experience of settling down in London (Phillipson et al, 2004). This is very similar to the experiences of the first generation of Bangladeshi women.

As Kabeer (2000; 268) records, for the first generation of Bangladeshi women in Tower Hamlets, the process of transition involved in migration was made immeasurably difficult due to the shock of contrast between the two different cultural milieus (this will be discussed later). However, for the current third generation of British Bangladeshis who are English educated and dress differently, did not have to go through the initial problems of settling down in a new country. Thus, the different generations have had different experiences.

This study is about the first generation of Bangladeshi women who arrived at a time when there was a lack of affordable housing and scarcity of accommodation for larger families (Gavron, 1997; Pollen, 2002). It is this population who have been the subject of paan research during the last few decades (Bedi, 1995; Croucher et al, 2009). However, during the fieldwork and within respondents' households, it was possible to meet and communicate with remarkably diverse groups of Bangladeshi women. They had different opinions and understandings about the way of life in Tower Hamlets and in England.

Unlike over twenty years ago, the youth who were brought up in England after a stay in Bangladesh, would now prefer to select a partner from the local Bangladeshi community rather than from Bangladesh and love marriages too are not rare. For example one woman said:

> My son married Punjabi girl … my relations don't like it ... her father din't like ... but when I said it is our child ... we must not scold him … he said ok she is Muslim but later we know she is not Muslim, Sikh … Then after some time he said never mind ... he is a man ... We laughed … we, me and my daughters ... I have three, two married and other one says she will wait … but everybody ask why she not married (Salma)

Other researchers have commented on the changing attitudes of women. As Phillipson et al, (2003) pointed out in their study, when asked about the opinions of people; mothers were keen to stress the benefits of their children choosing partners for themselves. The way in which the women have been

advocates for education and career development of their daughters will be further discussed in the next chapters. As observed during the fieldwork period there are other transitions in the dynamics within the Bangladeshi families.

Cultural dynamics of transition

The household relationships reflected the cultural dynamics of transition. For example it was commonplace that the siblings in families communicate with each other in English whilst communication with the parents was in English and Sylheti. Often the younger children (of primary school age) communicated in Sylheti and the teenagers usually answered parents' questions in English, the parents did not seem to mind this. This trend was of particular interest because several years ago, when I worked with Bangladeshi communities, their English language skills, especially among the housewives, was minimal and it was necessary at times to seek the assistance of children for translations. However, there is a remarkable change now as identified by this research and comparatively more older women are able to speak in English. Even when in doubt, they would try to express their ideas through their vocabulary in order to convey their perspectives. Their level of confidence was so remarkable that once, when I mistook a fairly big piece of tobacco to be a full leaf, the interviewee coolly corrected me immediately:

> No no no, (she interjected) ... You are wrong ... full zarda is too long you know. What I am saying is I mean you can buy small ones, I mean not small leaf ... maybe aada (half) or little or big piece ... you can buy

> the full leaf ... but too big for ... me ... we don't want such big zarda ... I know it is cheap when you buy the whole..

At this point she got up and walked into the kitchen and returned with a long leaf of tobacco to convince me. Present day older Bangladeshi women in general are much more assertive than when they were young, partly due to community education programmes they have attended to learn English. In addition, perhaps the hardships they have gone through has also made them stronger and resilient. Another reason for their fluency in English is that these women acquire language skills from their children who are either in secondary schools or have left school altogether for higher education or employment and they communicate with their parents in English. These women watch both English and Bangla television which provides them with the entertainment they need and feeds their hunger for nostalgic memories.

Although the Bangladeshi women in this study are Muslim, this is only a part of their identity. All of them said that they are Muslims, but they also referred to themselves as Sylhetis (21/30) and Bangladeshis (9/30). Among Bangladeshi men there was a strong emphasis on their religion whereas for women the focus was children and family. Some women covered their heads and some did not. Some (17/30) strictly consume halal meat from Muslim butchers while the others (13/30) were not that strict and enjoyed an occasional burger at McDonalds.

The group of women in this study spent their time shopping, cooking and caring for the family. There are older adults in the households and their influence on the preparation of food and child rearing traditions are passed on

to younger mothers. It is acceptable for three generations to live in the same house. At times, this created conflicts within the younger generation who may not agree with their elders' ideas, such as child rearing habits and dress codes. Some of the women are engaged in cottage industries, such as tailoring for local businesses. However, this trend is declining because the cloth factories are being moved to Bangladesh. The women enjoyed working from home because it gave them extra money and a feeling of financial freedom.

They admire cosmetic products and embroidered lingerie. There was a touch of embroidery in their clothes, soft furniture, linen, and even the covers for boxes of tissues. Those who covered their head showed their beautifully embroidered scarves with different colours to match their saris. They had the economic wherewithal to buy Bangladeshi goods that reminded them of home, as well as to purchase what they considered as British things such as lingerie, perfumes and cosmetic products, thereby recreating a comfort zone within their households. Bangladeshi women also have positive comments about the area. One young woman, Zahra, who works in the city said:

> We cannot have this kind of life in Bangladesh; here we have best of both worlds. Sometimes I ask my mother when she grumbles about cold ... do you want to go back ... and she says No... No...No... I am not asking to go; it is just my bones. Even in Bangladesh your bones will hurt I told her" (Zahra, participant of a workshop).

Zahra further stated that her parents would never want to return and settle down in Sylhet although some of her relatives have already retired to Bangladesh, having lived in Tower Hamlets for over 25 years.

> They built a really beautiful house in Sylhet city with modern facilities and joined the other ‘Londonis’ in the city. My parents kept on sending their money to relations in Sylhet and they expected more and more.... no end to it so they improved their houses and now when we go we have to live with them, after a while we feel uncomfortable, I mean my sisters and brothers, but my parents feel ok, they don’t understand why, you see there is no privacy when you live with a family, last year I went for a funeral and stayed in a hotel, but my mother did not like it, when I came back she had a go at me.

Sylhet city has houses built by Londonis and it is the dream of many Bangladeshis to earn money and invest in a big house in Sylhet. However, as mentioned before, some of the families whom I visited, despite supporting their kith and kin in Bangladesh, were not able to build or invest in anything for themselves. This has caused much resentment among the British-born younger generation who feel that their parents have been exploited by their relatives in Bangladesh. The subjects in this study, however, did not show such sentiments. either because their expectations were different from those of their children or because they did not want to show their dissatisfaction.

Conclusion

In order to place the respondents of the study in their present and past contexts, this chapter described the demography of the current home environment Tower Hamlets and, their childhood habitat Sylhet, the region where the Bangladeshi women of the study lived before coming to England. In brief, the chapter examined the issues related to the life of earlier immigrants in order to compare the problems faced by earlier and subsequent immigrants of different ethnic groups on their arrival in the East End of London. Since the departure of the subjects of the study from their original homeland, Sylhet has undergone many changes and currently there are British Bangladeshi businesses thriving in the region of Sylhet. Similarly, as a result of the large Bangladeshi population living in the borough, Tower Hamlets has seen major changes including the creation of spaces such as Bangla Town. As a result of these changes, the residents of Sylheti origin can now enjoy the material culture they left behind when they migrated to England. Chewing paan is part of that Sylheti culture, however, it is not exclusively 'Sylhetish' because it is a practice shared by many communities in Asian and South Pacific regions.

Despite the fact that paan use is a practice shared by Asian populations, the question arises as to what makes Bangladeshi women, and more specifically women of this generation, more vulnerable to paan chewing than other women of Asian origin. The biographical trajectory of these women runs parallel to the changes in the social space of Tower Hamlets and may shed light on paan use among this population. These parallel biographies are

particularly useful because a chronic condition such as dependence and habit forming occurs over a long period of time and the personal stories including comments on the changing environmental circumstances will help to elucidate how the problem forms and develops. As Williams (1993) emphasises, there is a need to understand illness in terms of the patients own interpretations, of its onset, the course of its progress and the potential management of the condition, all of which are embedded in their biographical and cultural contexts.

CHAPTER 5: RESEARCH FINDINGS: EXPERIENCING PAAN ADDICTION/ DEPENDENCE

Introduction

In the last two decades, a significant number of studies (Goldstein, 1994) have indicated that long-term drug use and addiction is a complex phenomenon, which involves a whole range of interacting factors; subjective, neurobiological and socio-cultural (see also: Larkin et al, 2006, Graham et al, 2008). However, medical research studies often examine long-term drug use on a purely biological level, which does not consider the subjective and socio-cultural factors involved. For example, studies on paan use among Bangladeshi women have measured dependence according to a medical model for nicotine dependence – an addictive substance (Croucher et al, 2002). These findings constitute Bangladeshi women as paan 'addicts' because they use a substance that contains tobacco. However, this is a reductionist view of drug dependency and addiction, which as already indicated is a complex phenomenon, involving a whole range of subjective, neurobiological and socio-cultural factors (Graham et al, 2008). Critically, existing research has not examined the complexity of the socio-cultural factors that influence Bangladeshi women's 'addiction' to paan. As a result the knowledge related to paan use is limited to its carcinogenicity and addictive nature. As drug use and addiction is a subjective experience (Graham et al, 2008) it is necessary to closely examine how drug users subjectively describe their paan drug use in their own words in order to better understand their

experiences and examine whether they correspond to the medical framing of drug use or not. Critically, the scarcity of research into paan use among Bangladeshi women in England means that medical professionals do not have access to empirical research data about the complex social and cultural factors influencing these paan practices, which means that they cannot make informed judgements about their paan use or make appropriate medical decisions about intervention strategies. Thus, research is required to understand paan drug dependence in a more holistic way in ways that intend to highlight the limitations of existing paan cessation provisions in England and bring about positive changes in the way health professionals address the issue of paan dependence.

This chapter intends to address this research need by closely examining how Bangladeshi women in London have become dependent on paan, and the complex subjective, neurobiological and socio-cultural factors involved. The chapter will begin by examining the medical definitions and models of addiction. The addiction process is understood as a combination of three layers (aspects); neurobiological adaptation in the brain, the manifestation of individual addictive behaviour and the sociocultural factors that influence addictive behaviour. This chapter will mainly focus on the first two layers. It examines the neurobiology involved in drug addiction and the ways drug addiction, including paan addiction, manifests in individuals on a physical and psychological level. The third layer is discussed in Chapter Six which draws on ethnographic research data to closely examine the socio-cultural factors involved in paan use among the study participants. It will focus on examining Bangladeshi women's own experiences of paan use and compare it with the

medical description of drug use to determine whether they align or not. This is crucial in terms of identifying similarities and differences between the medical points of view and the drug users' accounts of dependence.

Medical definitions of addiction

Edward and Gross while working with people who were alcohol dependent came up with the idea of a bio psychosocial model and introduced the first definition of Dependency syndrome (Edwards and Gross, 1976). Although the term 'syndrome' is associated with medical diagnosis, "The dependence syndrome is a concept which is rooted in psychological, biological and socio-cultural constructs and which therefore invites no one 'level of expectation' nor the hegemony of any scientific discipline" (Edwards, 1986 ;181). It was accepted by the WHO for inclusion in the Tenth Revision of the International Classification of Diseases and Health Problems (ICD-10). Due to the term syndrome this is not a very popular model among psychologists and sociologists (see Babor, 1986). However, later it shaped the diagnostic criteria for dependence in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM- 111R). The ICD and DSM systems are the internationally accepted diagnostic criteria. The Diagnostic and Statistical Manual (DSM) IV–TR, describes addiction/ substance dependence, as a maladaptive pattern of chronic, relapsing use, which is diagnosed by a set of criteria that include tolerance, withdrawal, and compulsive drug-taking behavior in the face of negative consequences (APA 2000, 192–198, 2010). This definition by the American Psychiatric Association is used worldwide in determining the presence of dependence/

addiction. The World Health Organisation has adopted a much wider definition. It defines dependence as 'a state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug characterised by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience psychic effects, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present' (WHO, 2004; 2010). This demonstrates the fluidity of the concept and the difficulty in finding an all encompassing definition.

Critically, the main limitation of these medical definitions of drug addiction is that they include several explanations of neurobiology (organism and drug interaction in the WHO definition), characteristics of the physical and psychological discomforts as well as personal feelings and behavioural responses, but do not address the sociocultural and personal circumstances involved in drug addiction. For example, within the context of this study these medical definitions of addiction do not refer to the sociocultural and personal factors that have led Bangladeshi women to become 'addicted' to paan use. Other studies have highlighted the limitations of medical definitions of drug addiction. For example, Graham et al (2008) points out that the individual neurobiological level of analysis (the medical model based on brain chemistry), tends to preclude important additional layers of understanding, such as the role of intentional human behavior, the socially constructing processes of addiction and the role of gender. Over the years several researchers (Kelleher and Islam, 1996, Greenhalgh, 1998) have emphasised

the importance of understanding cultural differences in health and developing culturally appropriate health interventions. Keval (2009), whose study examines South Asian Hindu Gujarati speaking people's experiences of type 2 diabetes, recommends that practitioners should be encouraged to maintain a view of culture and ethnicity as dynamic entities so that service providers can more fully engage with the needs of service users through a critical social and cultural understanding of people's needs in diabetes management. At present, the scarcity of research into paan use among Bangladeshi women in England means that medical professionals do not have access to empirical research data about the complex social and cultural factors involved in these drug practices, which means that they cannot fully engage with the needs of these individuals. As I have previously indicated, research into paan use has been taken from a medical view of addiction (see chapter two). While it is helpful to understand the medical view of drug addiction, it is important for health professionals to understand the three different layers of drug dependence in terms of, a) how a drug, such as a paan, creates a neurobiological adaptation or change in the brain, b) the way a drug manifests as addictive behaviour and c) to what extent drug addiction is facilitated by the sociocultural environment and autobiographical experiences.

Neurobiological adaptation (first layer)

Understanding the physical neurobiological aspects of the addiction process can help to raise empathy and awareness among health professionals and users. The neurobiological adaptation to psychoactive substances is known as the reward pathway (Goldstein, 1994). Reward related behaviour in

humans is a well documented area of research (Teegarden, 2009). The reward pathway is a neuronal adaptation activity in the brain. Dopamine, serotonin, glutamate and gamma-amino butyric acid (GABA) are some of the neurotransmitters of relevance to understanding the relationship between the reward pathway and addiction. They also play an important role in feelings and emotions. In the brain there is an area identified by scientists (Koob and Goeders, 1989) as the 'dopaminergic pathway' which is responsible for feeling good. This is also known as the 'reward pathway'; when the reward pathway is activated it creates a feeling of wellbeing and happiness in people. It has also been established by scientists that dopamine effects in a reward pathway are enhanced by some psychoactive substances such as cocaine, amphetamines, opiates, nicotine and alcohol. In other words psychoactive substances can create a similar feeling of wellbeing when ingested. Thus, the ability to stimulate the reward pathway is what makes a psychoactive substance such as nicotine addictive. When a psychoactive substance constantly enters the reward pathway, the brain gets used to it. Over a period of time the amount of the substance needed to activate the reward pathway gets increased. If not, the reward pathway will not be activated and create anxiety and unpleasant feelings. In addiction terminology this discomfort is known as withdrawal symptoms. In order to avoid the unpleasantness due to the withdrawal users will continue to take the substance they are used to. As I will later indicate, the women who participated in this study avoided withdrawal symptoms to paan by continuing to take it. However, as drug use and addiction is a subjective experience, (Graham et al, 2008) it is necessary to closely examine how these participants' subjectively describe these paan

related experience in their own words in order to better understand these practices and examine whether they correspond with the medical framing of drug use. For example, in the following interview extract, one of the participants, Samira, who came to Britain in the early 1980s and did not use paan at this time, indicates that her own experiences of using paan emerged within a social context where the negative health effects of paan use and its addictive nature were unknown. This does not clearly correspond to the medical model which presents addictive behaviour only in terms of a physiological process.

> … I had 6 children. 2 went to uni and others got jobs and also married ... then in '95 my friend Rozy ask me to come to Koran class. In the Koran class some women chew paan and after some time me also ate. It is like a must now … I don't know how I liked paan and … zarda … my son tell me mum you are addicted. I think he is right … I think ... I am addicted ... I mean now ... because I want paan so much ... (Samira 64).

In this interview extract, the participant explains how she was first given paan by Bangladeshi friends in an everyday social context - a Koran class. She then describes how she only became aware that she was 'addicted' when her son pointed this out. She then realises that 'I think he is right….I think….I am addicted…because I want paan so much'. Her response indicates that her use of paan had a positive impact on her social interactions with others in the Koran class, who were also engaged in this practice. For instance, her paan use began as just an act of sharing between friends within this social context

(see the next chapter), which later became a habit that continued even without the company of others. Now, it is an activity which she finds difficult to cease. Samira's dependence on paan is evident in her statement 'I want paan so much'. She acknowledges that her dependence on paan indicates that she is 'addicted'.

Although the term 'addiction' is commonly used by people in social contexts, it has very specific meanings within an academic context as shown above in the ICD 10 definition. During the interviews, some of the women (14/30) used the term 'addiction' to describe their attraction to paan. It was established that someone, perhaps a family member, a friend or a health professional had used the term which they then picked up and used in their conversation. The other women in the sample used phrases similar to, 'I have to eat paan'. The following are some of the phrases used by the participants (30/30) to describe their dependence on paan.

'I can't stop paan';

'I get pain if I stop'. 'If I don't eat paan, I get headache';

'When I get up, I have to eat paan ... otherwise, I get headache';

'If I try to stop then my heart goes like ... you know … quick like ...and I know if I eat paan I can calm down';

'I only eat because of teeth … my mouth … teeth pain if I don't eat zarda'.

Based on the medical diagnostic criteria cited earlier (APA 2000, 192–198), the participants' descriptions, which indicate the physiological and

psychological discomforts they experience in the absence of paan - anxiety, headache, restlessness, toothache, nausea and compulsion to take paan, appear to be signs of withdrawal that confirm their drug dependence. The physical symptoms of paan dependence are well understood by medical practitioners. Nevertheless, one can assume – and not all health professionals do – that these serious symptoms must impact on women's perceptions of wellbeing and their decisions to seek help. There is a double ambiguity here. For these women, the line between the physiological and psychological discomforts they feel as a consequence of paan use appear to blur their judgement that these discomforts point to serious medical issues that require medical attention. Critically, addressing these health issues can also be difficult for the health professional involved. For instance, if the health professional involved is not cautious, the health issues of these raced and ethnic minority groups can be treated as simply 'cultural' practices, which can thus be neglected. As discussed in chapter two, the use of static definitions of culture in public health research risks homogenising ethnic groups and perpetuating racial/ethnic stereotypes (Hunt et al, 2004), and it can inadvertently promote victim/blaming explanations (Viruell-Fuentes, 2011: 38). Researchers (Kelleher and Islam, 1996; Keval, 2009) have highlighted the complex nature of health choices people make when identifying problems and choosing treatments.

Published literature on paan use among Bangladeshi women (Croucher et al, 2002), have used ICD-10 criteria described above in establishing the presence of dependence. The respondents in the current study consumed the

first paan quid of the day within the first half hour of waking up. The severity (degree) of dependence related to substances can be ranked according to the scale of how difficult they are to quit. In such a scale nicotine is rated as the most difficult to cease (American Cancer Society, 2012). In addition to nicotine, the use of areca nut means there are two stimulants together producing an effect of summation in terms of drug interaction (British National Formulary, 2005). Habiba, one of the participants said, 'If you want a very taste one (meaning tasty) then 'gua' and 'zarda' ... you want … only zarda is not good ... not taste but you put everything ... then it is good'.

When questioned about the difference in taste she said that gua and zarda, meaning areca nut and tobacco, together made the betel quid tastier. It was difficult to understand what she meant by 'very taste one', however when probed the respondent clarified it as tastier. Another respondent explained that it is like adding salt and lime juice to a salad. 'One alone is not good ... both together is tasty salad'. The effect of the combination is clear. Tobacco and areca nut, two stimulants together made the paan quid both more addictive and more attractive. In addiction terminology, this is described as a synergic effect due to the presence of two stimulants. While it is evident that the women are dependent on paan it is necessary to understand the second layer of the medical framing of addictive behaviour – how addiction manifests outwardly.

Manifestations of addiction (second layer)

The medical framing of addictive behaviour describes the features of outward manifestations in terms of individual needs and feelings. Addiction is

conceptualised as being composed of multiple elements or features (Griffith, 2005). Based on their extensive research on published literature on addiction, Sussman and Sussman (2011) established that there are five main elements; i) feeling different, ii) preoccupation with the addictive behaviour, iii) temporary satiation, iv) loss of control and v) negative consequences, which have been most popularly suggested as being constituents of addiction.

i) Drug addiction and emotion: feeling different

Addiction/dependence does not develop as a sudden condition, it manifests over a long period of time depending on the nature of the behaviour and personal circumstances. It has been theorised that all addictions may share a function to shift subjective experience of self, (Larkin et al, 2006). This has been suggested even earlier by Goldstein (1994) as explained through neurobiological activities within the brain. However, these neurobiological changes or addiction processes seem to unfold only for some people and not for others; not everyone who enjoys a drink of alcohol becomes dependent on it. Similarly, there are individuals who use stimulants and other substances including paan without showing any signs of dependence. It has been suggested that addiction may reflect specific emotional states that the individual experiences prior to engaging in the addictive behaviour. These specific emotional states include; feeling lonely, agitated, restless, uncomfortable or incomplete (Jacobs, 1986). However, these emotional states or traits alone cannot explain drug use. For instance, within the context of this study Bangladeshi women's paan use cannot be explained just by the specific emotional states that they experienced prior to engaging in paan use. Their

paan use and dependence is more complex, according to their narratives paan use did not start as a reaction for feeling different.

The ethnographic observations over the study period indicated that there are physiological, psychological, personal and social aspects at play in Bangladeshi participant's paan use. For instance, the observations indicated that age, culture and ethnicity appears to be a factor in their paan use, in that these paan practices are particularly common among this particular generation of Bangladeshi women. However, it should be noted that not all age groups or class groups in the Bangladeshi community in Britain chew paan. Croucher et al (2002) indicate that culture is a factor in paan use among Bangladeshi women. For instance, they indicate that Bangladeshi men in Britain and abroad commonly smoke and women chew paan; it is less acceptable for these women to smoke or drink. The research findings indicated that paan use varies across geographical cultural contexts. For example, the participants indicated that their relatives in Bangladesh chewed less than they did; this will be discussed later.

The participants' autobiographical experiences also gave some insight into their paan use and dependence; the next chapter will indicate that participants often began to use paan, and became addicted to it during a positive period of their lives in England, and not when they first arrived as immigrants in this country, a time most of them found difficult. These research findings indicate some of the socio-cultural factors involved in participants' paan use and dependence.

Critically, the physical aspects of drug dependence also merit attention. Substance use varies because an individual biological or genetic susceptibility to the drug varies, For example, studies have indicated that 50% of addictive behaviour has a genetic predisposition (Goodman, 2009; Sussman and Ames, 2008). It can then be argued that the other 50% of the behaviour may be the result of the social and environmental circumstances. However, critics of biological explanations of ethnic health inequality point out that, genetic factors do not sufficiently account for the observed ethnic variations in health (though this is a behaviour that has an impact on health – perhaps similar to diabetes); or indeed in this case age and gender too. This is particularly so when other possible explanatory factors such as social, behavioural and environmental circumstances are taken into account (Lee et al, 2001). For example an encounter with a gambling machine on a casual visit to an amusement arcade can lead to a dangerous gambling addiction/dependence for some individuals but not for everyone. In this case the subject's initial reaction to the potentially addictive behaviour can be more positive and more enhancing than with those who are relatively less prone (Nordenfelt, 2010). This means that some individuals in society will be more vulnerable than others towards addictive substances or addictive behaviours. Similarly, not all Bangladeshi women who live in Tower Hamlets, East London under similar circumstances to those who participated in this study are dependent on paan. Critically, this study found that there were significant variations in the participants' level of dependency to paan. For instance, while some women had eight to ten paan quids a day, some women slept with a paan quid in their mouth.

These findings indicate that there seems to be an existence of a spectrum of addictive 'appetites' that fall along a continuum (Foddy, 2011). This would indicate that only some individuals will exhibit certain behaviors and preoccupation with drug use that are recognized to fall within this continuum. This is another limitation of using addiction criteria to understand dependence among Bangladeshi women. Preoccupation with addictive behaviour is another debatable criterion for establishing dependence. It is therefore helpful to understand the main features of addiction from a medical point of view before further examining participant's views on their paan use and addiction.

ii) Preoccupation with behaviour

Preoccupation refers to another element of addiction manifestation (Sussman and Sussman, 2011) described as excessive thoughts about getting engaged in a particular behaviour, despite potentially diminishing appetitive effects (Robinson et al, 2008). This also meant that much time is spent thinking about the behaviour and less time is allocated for other activities (Campbell, 2003). In dependency syndrome, this is described as the salience of the substance seeking behaviour. The drawback with addiction criteria is that it is mostly based on drug and alcohol related behaviour, as such, all dependent behaviours are clustered together under one concept or category. It is not possible to clearly establish whether Bangladeshi women are preoccupied with a paan habit. It depends on how preoccupation is perceived by different people, when referring to paan use. For example, this study only aimed to understand what the respondents' accounts were. There is no standard

measure for preoccupation which can be applied to all types of addictions, so it is highly subjective.

One of the interviewees, Razia, a 50 year old Bangladeshi woman who has been using paan for over 32 years, said that she never thinks of paan as a necessity. She agreed that her consumption depends on the availability at a particular time. In her household paan was never scarce because her elders used it consistently. Thus, it appears she did not have a 'preoccupation or salience of paan seeking behaviour' as stated in the dependence terminology. In the following interview extract, she remembers an incident that took place 30 years ago, where she describes her dependence on paan at this time.

> I can go without paan. When I went ... my in laws in Coventry ... they did not have paan and I was shy to ask, their children, they are my age but not married and in the Uni, ... so they dint eat paan and I dint want them to see that I am stupid and chewing this rubbish ... For one week I dint eat, I felt headache every day and wanted to run home, but I just waited. If I really wanted I could have got from the grocer, but I thought no ... when I look in the mirror oh, it was so nice my teeth and my mouth ... After one week, you don't believe, I came home and saw the paan daan and thought, no, no, I don't want ... but ... Evening I thought so what, I will eat it ... May be one day I will give up.

In this interview extract, there is a sense that Razia has developed a dependence on paan, which is evident when she acknowledges that she could not resist the sight of paan daan in the evening. For instance, she indicates that though she notices that her appearance, particularly her teeth

and mouth, look better because they have not been blackened by paan use when she is not using paan, she is not able to resist it. Those who advocate dependency syndrome will consider this as the 'compulsion to take the substance' and also 'reinstatement of the behaviour' (The ICD-10, 2003), both of which are among the main features of dependence.

At a later point in the interview, when asked if she had been without paan recently, Razia explained that every year when she goes to see her relatives in Coventry, she will refrain from chewing paan for shorter periods because her relatives do not use paan.

> If I really want it I can always get it…but I don't know I don't want to eat paan when I am not at home…can't be bothered you know...but when I come home just chew it again…otherwise I don't think of eating … when I go to Bangladesh I don't eat paan ... too much visiting you know ... so I can wait

This interview extract indicates that the participant makes an effort to refrain from paan use when she is around her relatives, which suggests that her relatives do not approve of paan use. The participant's ability to abstain from paan when she desires is an interesting phenomenon. However, it is difficult to say whether she has a preoccupation with paan or not; when there is a preoccupation with a substance the user's priority is to obtain the substance and use it. Alternatively, it is possible to argue that even in the absence of a preoccupation (according to her assertion or researcher's interpretation) Razia did not want to give up her paan use even though she noticed that her appearance had improved when she was not using it. It is difficult to explain

her ambivalence (another sign of her addiction) However, in the previous interview extract she indicates that she did not eat and experienced headaches when she did take paan, which can be read as withdrawal symptoms or the tell-tale signs of physiological addiction. Consequently, can one say that Razia is addicted to paan? Why did she experience headaches and a desire to run home? Theorists from different disciplines may explain the participants' behaviour in different ways. For example, academics in the medical field will likely focus on the individual and sociologists may focus on the socio-cultural issues related to the behaviour. However, as previously indicated, the participants' withdrawal symptoms are the tell-tale signs of physiological addiction. Was Razia craving paan so much that when she came home she could not resist the paan daan? Craving refers to the urge to engage in addictive behaviour, and has been a hallmark defining feature of the addictions (Meyer, 1996).

Arguably, craving can be considered an aspect of preoccupation. However, depending on the type of behaviour or the substance, craving takes different forms, for example cocaine although considered a highly addictive drug, does not cause strong physiological withdrawal symptoms such as the physical tremors associated with alcohol withdrawal. But, cocaine addiction is identified by drug seeking behaviour while in the midst of accumulative negative consequences (Potenza, 2010); to relieve the physical withdrawal symptoms of cocaine addiction drug seeking behaviour becomes the priority for the user. Nicotine, as seen in smokers, causes severe cravings. For instance, the Bangladeshi women who participated in this study acknowledged that they had experienced severe nicotine cravings when they stopped using it. Razia's

assertion that she is able to go without paan is described as a temporary satiation in the field of addiction. However, this is debatable because this concept does not explain the behaviour of those who quit substances or a dependent behaviour without much hesitation or intervention. This demonstrates that the medical terminology does not fully explain or account for the varied and fluid behaviours of substance users, including those in this study

iii) Temporary satiation

Studies have indicated that after an intense engagement of addictive behaviour, there comes a short period of quietness, during which addiction craving ceases for a while, but to be re-engaged soon thereafter (Foddy, 2010). This short period of quietness is referred as a period of 'temporary satiation'. However, the research data indicated that this was not always the case. For instance, in the interview extract I have just analyzed, Razia did not experience a temporary period of quietness, but rather shifted back and forth between the 'need to obtain paan' and the 'goal-orientated need to look nice in the mirror'. These varying states show the typical ambivalence that exists in dependence.

Alternatively, it could be argued that during this period of temporary satiation, perhaps the individual becomes preoccupied with or distracted by other important activities in their social context. For example, a person who is dependent on a substance will often become preoccupied with or distracted by a busy schedule, a new job or a relationship or self-realisation itself, which may prompt a period of temporary satiation. As for the women in the study

sample, it can also be argued that when they are outside the cultural space where paan use is not considered a social activity, they will refrain from chewing for a while but often relapse into using it when they return to these spaces where paan use is acceptable.

However, individuals who successfully quit their addiction, indicate that it is possible for some to quit an addiction such as smoking, without any outside help. This is a conscious effort and cannot be explained in terms of addiction criteria. For others, successfully giving up the substance they are addicted to is not always possible. For instance, in the following interview extract, Nazma, a 57 year old Bangladeshi woman, who has been using paan for over twenty years, indicates that voluntary cessation of paan is not possible.

> I always want to stop paan … then I think with Ramadan I will not start again ... I will promise not to eat again … but after 3 days … in the evening soon after eating dates I will eat paan

In this interview extract, the participant indicates that even during the Muslim religious period of Ramadan, a time when Muslims fast and abstain from all fluids and food from dawn to dusk, she promises herself that she will give up paan, but after 3 days returns to using it. During Ramadan, the women in the study sample did not consume paan until the evening. Five women were interviewed during Ramadan. Nazma's comments, mentioned above, are similar to those of other women. During this period, they read the holy Koran and think of making some positive changes in their lives. Some women (23/30) indicated that they considered quitting paan, but were unable to do so. In the evening, when they break their 'fast', it is customary to eat a date as the

first food. Some women (13/30) reported that they would have paan soon after their breaking evening fast, similar to Nazma, the participant interviewed above. Others would have paan after their main meal. Either way, this can be considered as a very short period of self-imposed temporary satiation which becomes necessary due to religious obligations. However, while conducting the ethnographic research, it became evident that this short period of abstinence has much meaning for them. This is evident in the following interview extract where Halima, a 57 year old Bangladeshi woman explains how she feels when she is able to give up using paan for short periods of time during Ramadan.

> I think it is very good we have Ramadan … I mean I feel very good … I can do something difficult. Fasting is not difficult ... you feel hungry and it is not difficult … but if I don't eat paan I get headache and toothache … that is the difficult thing ... I feel like shouting … but … I think of Allah and I know he is looking ... so I have to be good... so I like it ... no food no paan … one day is not difficult.

This interview extract indicates that Halima feels 'very good' when she is able to sacrifice her much loved paan for her Muslim religious faith, which gives her some kind of comfort. Though she acknowledges that when she does not eat paan she gets headaches and toothaches, but she is able to abstain because, 'I think of Allah and I know he is looking…so I have to be good'.

These research findings indicate that the participants' period of temporary satiation occurred when they observed their religious obligations during

Ramadan. So, the concept of temporary satiation is open to different interpretations. However, as for understanding paan use among the participants, temporary satiation is not a very convincing defining element of addiction but in the absence of an alternative explanation, this may be only one way of looking at it as a feature of dependence. However, the participants' autobiographical narratives indicate that their paan use experiences are not uniform, in that they varied across the diverse individual, social and cultural contexts. For example, their paan use varied depending on their own perception of their paan use and on whether they determined it was appropriate at specific social, cultural and religious contexts. Nevertheless, all the participants identified themselves as problem-users of paan when they said that they are addicted to paan.

The research data indicates that a temporary period of time without paan does not necessarily constitute a feature of addiction, but rather as a consequence of the participants' individual and social circumstances. Different academic disciplines will assign different terminology for this condition. In the field of addiction, if an individual starts consuming psychoactive substances after a period of abstinence, it would be interpreted as a 'loss of control' over the substance on which the individual is dependent.

iv) Loss of control

'Loss of control' was a frequent and reoccurring theme, which emerged throughout the research. According to the participants, 'loss of control' meant not being able to control or stop their paan consumption on a regular basis. Critically, the participants' experiences differed from person to person. Some

participants felt that they had no control over their use of paan, while others said that they have control over when and with whom to use paan. However, all the participants (30/30) reported not having any control over their first paan quid in the morning. This is one of the assessment criteria on which medical practitioners establish drug dependence (Croucher et al, 2002)

The first treatment model for alcohol dependence was established in the United States as a religious organisation (Jellineck, 1960). Popularly known as the 'AA' (Alcoholics Anonymous), it emphasises 'loss of control' as the guiding principle. Within this context, 'loss of control' means the inability to stop or control consumption of alcohol. In other words it is believed that the addicted people have lost control over their life and instead, alcohol has taken control over the addicted people's lives. Alcoholics Anonymous has a global fellowship covering many countries. As an alcohol prevention programme, it highlights the significance that social determinants, such as individual, family and social circumstances, play in the onset of addiction. This gives the user certain comfort in not being labelled or blamed for self-inflicting the situation.

Research data in this study also highlights social determinants, such as individual, family and social circumstances, play a part in the onset of the participants' addiction to paan. For example, research data gathered through fieldwork and interviews indicated that the use of paan among Bangladeshi women in the current study is influenced by their socio-cultural context, and has developed into an addiction, which is somewhat beyond their control. Difficulty in refraining from an addictive behaviour, despite attempting to do so, may be central to the loss of control aspect of addiction/ dependence

(Heather, 1998). For example, this is evident in the following interview extract, where Farida, a 65 year old mother of five and a grandmother of four children, describes how her consumption of paan has developed into an addiction, which is beyond her control.

> I think ... we, I mean our Bangladeshi people, can't control like me ... I think I can, but I can't ... I know Ramadan is very difficult. I can wait without food but paan and zarda ... I can't. I can shout when I want it ... bad headache and teeth pain and ... oh we can't without paan.

These addictive 'out of control' feelings are also evident in the following interview extract, where Shazia, one of the participants in the Koran class, said that paan is a curse.

> You don't know how I suffer … I can't sleep without paan. My mouth pain is terrible, my children shout all the time, they don't understand … this is my curse ... I can't tell anybody, they tell me stop paan you okay then … I can't stop. Pain is terrible if I don't eat paan. I take it with me when I go out … can you see how difficult.

Shazia sleeps with paan in her mouth. Her tobacco intake is high. She uses tobacco leaf as well as the paste which is highly concentrated. Her extreme addiction to paan, which clearly is having a negative impact on her health, raised serious moral and ethical issues for me, as I felt responsible for providing her with information about how to quit her paan habit after our interview. Consequently, at the end of the interview, I gave her a leaflet for the paan cessation programme in Tower Hamlets.

Loss of control, due to severe use and withdrawal, is a recurrent problem within this study population. However, their loss of control does not necessarily spill into other aspects of their lives. Some addictions may lead to severe consequences such as feeling compelled and sensing incomplete control. It is also observed that they may disregard even basic self-care, suggestive of a loss of will (Nordenfelt, 2010). This assessment criterion is not appropriate or applicable in the case of paan dependence. This is not a feature observed among Bangladeshi women in this study. None of the participants disregarded their basic self-care; their loss of control is only limited to their paan habit. Studies have also suggested that the relative emphasis placed on 'appetitive' versus 'loss of control' aspects of addiction, vary across various age ranges. For example, (Chassin, 2007) indicates that adults tend to view the loss of control aspect of drug addiction as more important than adolescents. This is an important issue to be acknowledged in drug intervention programmes for paan, as the women who are continuing their paan habit, are older and may be more receptive to health promotion activities. These health promotion activities are particularly important for older paan users, such as those in this study as the older the substance users, the greater are the negative effects of continued long term use of paan over a long period of time, which are mainly related to poor health. This is another area where health professionals dealing with paan use and dependence need to be informed about the importance of understanding and these individual and socio-cultural circumstances when delivering client-centred interventions.

v) Negative consequences

The fifth element of the addiction model is the unavoidable and most common feature - the negative consequences of drug use and dependence. This is an important aspect that can easily be overlooked by the medical professionals due to the fact that paan use is often seen as a cultural practice (Rooney 1993). As Nazroo (2001, 2003) points out there are various ways that ethnic minorities' health can be marginalised in England. For example, as discussed in chapter two, there have been a number of studies highlighting the higher rates of morbidity due to poor health conditions such as diabetes and heart disease among ethnic minority populations in England.

Engaging consistently with drug use even after suffering numerous negative consequences, such as poor health, is a criterion for dependence (Campbell, 2003). Similar to other defining elements of addiction, depending on the nature of the behaviour, negative consequences vary from mild to severe situations. The general practitioners, dentists, and health workers I met during field work, had concerns about health problems related to paan use which are the main negative consequences among the Bangladeshi population. A general practitioner said:

> These women have been chewing betel for a very long time. More than half of my Bangladeshi patients, I mean the women, are using tobacco. They all suffer from reflux and some have ulcers in the mouth as well as in the stomach. It is so difficult to convince them. My nurse always tells them to stop betel chewing. What happens next is that they avoid coming to see the nurse even for health check-ups. We have

> leaflets explaining in Bengali, but they don't understand what they are doing.

Every general practitioner I interviewed expressed similar accounts of the negative effects that repeated paan use had on their patients' health. However, in the above interview extract, the general practitioner interviewed interpreted his patient's continued paan use, despite ill effects on her health, as simply a 'lack of understanding' on her part. Critically, there is a need for this medical professional to develop more empathy towards these Bangladeshi women's addiction to paan and the sense of helplessness many feel in dealing with their addiction.

Many of the dentists I interviewed were concerned about their poor dental hygiene. For example, in the following interview extract, Rita, a dental nurse comments on one her patient's poor dental hygiene.

> We do not see them until they want to extract their teeth. Many of them have bad teeth and some of them have lost teeth. They are not interested in prevention. Unfortunately when they come to us there is nothing I could do other than extracting the bad teeth … They have this belief that tobacco is good for gum disease, it is very difficult to convince them … many of them get mouth cancer … there need to be a big campaign to educate this people … Fortunately, young people are not into betel chewing. Our students think it is disgusting.

This health professional clearly has serious concerns about the health and welfare of Bangladeshi women who use paan. However, this participant

appears to view paan users as being ignorant of their health and not compliant with medical advice. For instance, she states ‘they are not interested in prevention’. The majority of the health professionals I interviewed did not see paan use from the women’s perspectives. They viewed their continued paan use as non-compliance. The research findings indicated that the participants viewed their paan use not as non-compliance but rather as a source of shame. For instance, one of the participants admitted she was very reluctant to go to the dentist. She had lost a few of her molars and found it difficult to eat. However, despite these difficulties, she still did not like the idea of seeing a dentist because she felt a sense of fear and shame. This is apparent in the following interview extract, where Rafeya a 59 year old Bangladeshi woman, clearly feels a sense a shame about the poor condition of her teeth.

> All my teeth gone ... Nothing inside only these ... [She shows the front teeth which are severely stained and damaged] I can’t eat kaju [cashew nuts] or peanuts ... I like it very much but … my doctor shouts and tells why you eating this rubbish? Doctor tell who buy the paan and I tell him I buy because I have teeth pain. He give me letter to go to dentist ... I can’t show my mouth to dentist ... my GP is Bengali ... I don’t mind … can’t go to dentist.

As discussed in chapter two, paan use is prevalent among lower socio-economic groups in Asian cultures (Gupta and Ray, 2003). The participants initially view paan use as a lack of etiquette and social grace; the negative stigma associated with paan use developed over time, and it was not strong

when they were younger. When they initially began using paan, they did not realise that paan would negatively impact on their health, on the contrary they considered it as healthy. However, it is different now and Bangladeshi women are aware of the negative stigmatisation associated with paan use. For example, many of the participants indicated that they were aware that their children associate paan use with backwardness. The loss of control and the fact that it is seen as a habit of 'older backward people' who are uneducated, adds to their sense of shame. Given the obvious physical signs of paan use – stained teeth and loss of teeth, they often feel shameful of their appearance when they are in the company of others. Consequently their identity and sense of self is negatively affected by their paan use. These are important issues that health workers should be aware of when planning appropriate interventions within this group of paan users.

Due to the shame paan users feel they may be reluctant to seek help. The research data indicates that medical help is generally sought at the very late stages when medical intervention is the last hope. However, seeking medical help only at the late stages increases the risk of a serious diagnosis, such as oral cancer. The participants indicate that they delay seeking medical help in part due to the negative attitudes and stigmatisation associated with paan use, and also due to other reasons such as their perception of what is risk and illness. Many of the study participants did not feel that their paan use was associated with a high risk of poor health and they also did not view poor dental hygiene for example as an illness; instead they saw it as a cosmetic issue alone and a source of shame in their appearance. Bayer (2008)

suggests that there are occasions when mobilising stigma – around smoking for example – might reduce the prevalence of risk behaviours linked to disease and premature death. However, it can also lead to shame and avoidance of seeking help. Therefore it is inappropriate to generalise as to whether stigmatisation is an effective way of preventing paan use without understanding the underlying issues that motivate these substance use practices among the study population.

Bangladeshi women's perceptions of the severity of health risks associated with paan use is both a major determinant that motivates them to seek help as well as a barrier to getting that medical advice as they fear this information. This demonstrates the complex nature of treatment plans needed for paan cessation. This challenge poses another question related to the assessment criteria for establishing dependence. It places limitations in understanding the contextual and cultural nature of Bangladeshi women's paan use, which plays an integral role when designing and delivering interventions for this population. For instance, the research findings indicate that the participants' paan use is often based in specific social and cultural contexts. Thus, planning for effective interventions demands in-depth understanding of the social and cultural contexts within which paan users are located. Therefore, an exploration of participants' individual experience of paan use as well as the social and cultural factors influencing their continued dependence is paramount.

Paan use needs a different set of criteria to ensure it is being identified at an early stage well before the onset of dependence or any negative health

consequences. This study establishes that Bangladeshi women, who use paan, need to be screened for the health and severity of their oral condition. Physical dependence has been an issue among all the participants (30/30). All the respondents also demonstrated their desire to give up chewing paan. Although socialising events started with paan, in the absence of such occasions, women seemed to take paan to alleviate their physical discomfort such as headache, anxiety and oral pain in teeth and gums. They usually carry a small pouch with paan.

While paan dependence among Bangladeshi women had been established by some researchers at the time of this study, the respondents had not heard of any health promotion programme for paan cessation. The staff members of the ‘Stop Tobacco’ project reported that providing help for paan cessation is limited by funding restrictions. Government funding is mainly focused on tobacco prevention and this too is limited to smoking cessation. As such, paan is not in the health policy agenda and the existing work, if any, for paan prevention is carried out through the goodwill and interest of some practitioners, such as health professionals dedicated to the prevention of oral cancer.

The third layer of addiction, as already mentioned in the Introduction, is to be explained along with the findings of this study in Chapter Six, which explores the sociocultural factors that influence paan dependence.

Need for Paan cessation projects

At present there are no dedicated paan cessation projects at national policy level in England. The existing paan projects are initiated by various health professionals in a smaller scale at a local level. The cessation strategies are orientated towards relieving the discomforts of nicotine withdrawal. The methods used are similar to the smoking cessation programmes in which Nicotine Replacement Therapy (NRT) is offered to those who are willing to stop chewing paan. This is important at the beginning of the treatment; as observed in this study the participants spent much time describing their pain and discomfort. Slow releasing NRT patches will take the discomfort away temporarily. However, the long-term results of this approach are limited.

Referring to the smoking cessation strategies for younger mothers, McDermott and Graham (2006) point out that, grounded in quantitative research, interventions may fail to recognise – and therefore, fail to address – the factors which make smoking a particularly difficult habit to break for the highly disadvantaged group of women. Hence this impacts upon paan cessation strategies, such as NRT, for Bangladeshi women. Kakde and Bhopal (2012), who carried out a systematic review of oral tobacco cessation programmes, state that there is a need for more knowledge. Hence, understanding the women's perspectives related to their experiences and barriers to accessing services are important aspects of the development and delivery of effective interventions that can achieve long-term benefits. In addition, it is well established that, cultural and linguistic competence in

delivering health promotion programmes can enhance effective interventions further.

Based on Social Cognition Models (SCM), current tobacco cessation programmes also offer counselling support for those who need help with dependent behaviours. Unfortunately, there are not many trained Bangladeshi speakers who could offer counselling for this population. However, one of the observations made in this study was that an increasing number of female students are currently involved in health promotion initiatives and community development programmes in Tower Hamlets. There is much potential to attract these resourceful young people to deliver culturally specific counselling for Bangladeshi women who need help. Underpinning current tobacco cessation strategies is the assumption that individuals will be able to make rational informed choices. This, however, is debatable. In addition to the understanding of the aforementioned defining elements of addiction criteria, a clear understanding of the socio-cultural influence needs to be taken in to account in informing and raising awareness among health workers. It is also equally important to understand the user perspectives of dependency.

According to the Bangladeshi women who participated in this study, their life experiences have shaped their paan use. Due to the availability and affordability paan has become an everyday item in their lives. While they are dependent on/addicted to paan, it also functioned for them as a snack and a source of comfort. Furthermore, the majority of the respondents (23/30) believe that their paan use is excessive in comparison with women in

Bangladesh. For example, in the following interview extract, Riz, a 59 year old Bangladeshi woman, indicates that her excessive paan use is often frowned upon by her cousin in Bangladesh:

> My cousin told ... why your teeth are so bad and you eat zarda all the time, look at you ... she joked you know ... Londonis must look beautiful. I thought ... yes true ... she look better than me. I went to the mirror. It is bad. Really bad you know ... only the oldies eat all the time ... I am not old, I have to stop ... then I come in Whitechapel and start eating again. May be I dint eat that much in holiday.

Riz is not the only woman who felt that her consumption of paan is excessive when compared with that of her relatives in Bangladesh. Another respondent, Fazana, made a similar and equally significant point:

> My uncle's daughters eat paan only after food ... after lunch and sometimes night ... they told me, you are not like coming from bidesh (abroad) you are like women in the market ... My cousins are smart, I thought, true I am like market women … they told me to wash my mouth ... I dint like it ... I dint eat lot after, but I come back here and eat [paan] again.

This narratives indicates the general ambivalence this participant feels about her frequent paan use, which is in part due to her addiction to this substance. The respondents often compared themselves with other women who do not use paan. They are affected and perturbed by the way they looked when they saw themselves in the mirror with their stained teeth and lips, their oral

hygiene and their health issues. Despite these misgivings they are unable to quit paan due to the discomfort stopping the habit caused.

The women's accounts clearly indicate that they disapprove of their own continued use of paan. Between their experience of discomfort and shame (see earlier), paan use is bound or connected to their social position and identity. All the participants (30/30) have attempted paan cessation several times, but have been unable to quit. Compared with smoking, the negative physical effects of paan use are more visible and appear more quickly. At a younger age, women have experienced dental decay which they are ashamed of. Their concern about paan use is a positive sign which can be seen as an indication of their readiness for change. Bangladeshi women's ambivalence about their use as well as their readiness to change, (which will be expanded further later in the thesis) and their personal experiences of paan dependence, are critical to understanding their paan use, and thus must be an integral part of developing strategies and policies for paan cessation.

As McDermott and Graham (2006: 1549) contend, there is a wide gap in the qualitative evidence base of public health policy. It suggests that contemporary public health policy lacks grounding in the experiences of those whose lifestyles it seeks to change. In the absence of such information related to Bangladeshi women's experiences of paan use, these findings can play a crucial role in the development of public health interventions for paan cessation among Bangladeshi women. The next part of the thesis will examine the other three themes which explain the socio-cultural dimensions of paan use. Acknowledging these would help to inform health professionals a

wider picture of paan use that can be helpful when developing and delivering effective interventions for paan cessation among Bangladeshi women.

Conclusion

This chapter described the first two layers of addiction and tied it into the study participants' experience of dependence. The chapter indicated that participants' experience of paan use does not clearly correspond to the medical model of drug addiction, which does not account for the complex socio-cultural factors at play in drug dependence. For example, research data indicated that Bangladeshi women habitually use paan, in part as a consequence of complex socio-cultural issues. This has significant implications in that it indicates that health professionals involved in treating paan dependence and other health problems associated with paan use, such as dental hygiene and care and oral cancer, within this particular ethnic group, must take into account these complex social and cultural factors when making judgements about appropriate medical care.

The research findings indicated that the concept of neurobiological adaptation is helpful in understanding the drug related feelings of comfort and discomfort, many of the participants experienced while using paan. It also provides an explanation for the therapeutic value of the tobacco cessation treatment, NRT. Although, as indicated above, there are some limitations in applying these criteria for paan addiction, understanding the five elements of the addiction characteristics provides health professionals with a starting point to establish whether an individual is dependent on paan. Hence understanding the different layers of the addiction process (neurobiological adaptations in the

brain, the way addiction manifests in people and the sociocultural factors that influence addiction - the latter is dealt with in the next chapter.) is an integral part of developing and delivering effective interventions for paan cessation. It should be noted that the addiction process is not a fixed phenomenon; depending on the individual differences and the type of psychoactive substance, the manifestation of addictive behaviour will differ from person to person. Similarly, the same socio cultural factors affect people in a different way depending on their personal and social circumstances. Hence the complexities involved in addiction cannot be defined as a static set of processes; it is a complex and dynamic series of actions. The next chapter will further examine the sociocultural context of paan use (this constitutes the third layer of addiction) among Bangladeshi women in Tower Hamlets, which emerged from the narratives of research participants; the availability and social acceptance of paan use, 'Sylhetisation' and the lack of wider social involvement.

CHAPTER 6: RESEARCH FINDINGS: EXPERIENCES OF CREATING HOME

Introduction

The previous chapter discussed women's descriptions and representations of the physical and psychological features of paan dependence. This chapter concerns the other three themes that surfaced from the narratives of the participants' life experiences. This has particular relevance to the third layer of the addiction process which identifies and acknowledges the underlying issues related to the start and continuation of paan chewing that leads to paan addiction. During the pilot study and the first few interviews of the main study, it became evident that paan is not the most important or memorable aspect that recurs in the respondents' discourses. They were more eager to discuss matters related to their life experiences. Rather than merely reminiscing about paan as a commodity, their stories were mostly related to childhood memories of life in Sylhet, its rivers, tea estates, the rains and the muddy fields and their early lives in Tower Hamlets. Paan is just one sensory memory embedded in rich accounts of their biographies; although chewing paan is a social practice prevalent in Sylhet, it was not assigned a predominant position in their narratives. Their discourses demonstrated that chewing paan was not a practice established before they left Bangladesh. On the contrary, it is only a habit acquired after they migrated to Britain and though it is part of their past, their experience of Paan is very much tied into the lives they have made in the UK. It is an aspect of their identification that

has developed over the biographical trajectory of their lives and within the significant places they have called home.

Immigrant women such as Bangladeshi women have to reshape and integrate their cultural beliefs and values in order to adapt and adjust their lives within the new socio cultural environment. South Asian feminist writers (Gupta, 1999) have explored the ways in which identity, family and culture shape the lives of South Asian women when settling down in a new country. In the process of settling down in the new environment they may face multidimensional problems including sexism and racism. Their identities reflect these experiences and adaptations.

Identity is a highly contested area in social research and over the years, identity has been explored by many researchers. Currently, the definitions of identity have expanded through a wide range of disciplines including social science, political science and the humanities. Hence there seems to be no single agreed-upon definition. Brah's (1996) work on identity is of particular importance in that she explored the interactions of race, gender class, sexuality, ethnicity, generation and nationalism in different discourses, practices and political contexts. Based on her investigations (theoretical and empirical research) Brah (1996: 158) critiqued the ways in which identities are constituted and contested in the aspect of power relation as "……. 'regimes of power' articulate with those of gender, class, or other modalities' differentiation as they are played out in economic, political, cultural, and psychic spheres…..". Identity is a concept that is not fixed. Individuals and communities may adopt multiple, differing and changing identities, a process

affected by changes within differing contexts (Brah, 2007). This is even more complex for diasporic women such as the women in the study sample, because they may have to go through immense personal, sociocultural and emotional upheaval during their arriving and settling in the host countries. Hence identities are also integral to mental health and wellbeing as they determine to a great extent how a person understands their place in the world, and how they relate to others (Bostrom and Sandberg, 2011). Just as an individual's place in the world is constantly changing, so their identity is mutable and multiple; the identity of a teacher shifts to that of a mother when she comes home and attends to the children - she can also be a daughter and a carer for an older parent. Identities can also be elective; Bangladeshi women may consider themselves as 'belonging to a group of women who are addicted to tobacco', but that would only capture a minor aspect of what paan means to them and how they see themselves. Identities can be inclusive in terms of membership of a religious group or family, which the women in the study felt strongly. Identities can also be exclusive, defined by not being a member of a particular group. The respondents had mixed feelings about their place in the wider society; the study group did not feel part of the wider community. Nevertheless their biographies demonstrated achievements as well as adversity through adaptations and sacrifices. Paan use is an acquired practice that became an addiction in the process of managing the adversities, challenges and many complex facets of social life after leaving their country of origin.

Moving out from a very rural environment in Sylhet to an urban life in the city of London, over a period of over thirty years the women in this study have

negotiated and survived their changing and reversible identities and roles as a new bride, migrant, wife, young mother, home maker, grandmother and a carer for the family and now a carer for their extended family. The dynamic and spontaneous nature of these identities help prepare the women to perform everyday mundane tasks as well as to negotiate complex situations in order to tide over unfavourable conditions in the physical and socio cultural environment. The women had not been to cities prior to arriving in London. Their period of moving out from Sylhet and settling in London was a hard and challenging time, full of uncertainties, which they think they survived. Hence, their history of migration is central to their experience and also, for understanding the context in which they located themselves, living between two places and between the past and the present. Their nostalgic memories: beautiful verdant Sylhet and their childhood, settling and creating home in a major world city such as London, with many fears and anxieties, provided a detailed description of the experiences of their past and present lives. This chapter begins with the nostalgic memories that illustrate their circumstances and experiences. This will lead to a discussion on the other three themes that appear to shape the meaning of paan use within their personal history.

Nostalgic memories

The first documented evidence of the use of the term nostalgia was in the seventeenth century by a Swiss doctor, Johannes Hofer (quoted in Boym, 2001), to describe the homesickness of Swiss mercenaries, who, in the plains or lowlands of France or Italy were pining for their native mountain landscapes. This is similar to the experiences of the lascars who came to

England from Sylhet (Adams, 1987), as discussed in chapter four. Bangladeshi women in this study felt the same when they arrived in Britain for the first time. The respondents reported that they had experienced difficulty in settling down as nothing was familiar to them in London. They could not relate to anything including the food, weather or culture and they yearned to have the things they had left behind – the familiar sights and sounds of their native land and their staple food with its distinctive aroma and taste. They described their experiences of homesickness in terms of missing the sights, smells and tastes, the weather of home, missing family, getting used to their new husbands and the hostilities of the new environment, such as racism.

At the time of their arrival, East London had many social and economic problems such as unemployment due the closure of the docks and poor housing. Some members of the host community projected their dissatisfaction and frustrations towards the new immigrants (as discussed in the previous chapter). The new immigrants were seen as dependents that had come to take their share of the meagre resources of the East End. This expressed itself in the form of serious antipathy towards the immigrant community. Despite these difficulties, recent research challenges the superficial perceptions of migrants' experiences. For example, migrants are no longer seen as trapped between assimilation or nostalgia and the myth of return (Anwar, 1979). They are now seen as active participants who are part of dynamic processes of definition creating community cohesion, changing wider society. The Cantle report (2001: 15) has highlighted the features of diversity among the migrant communities and their adaptations to the local way of life in Leicester holding it up as a model city in terms of community

cohesion. The report goes on to say that diversity was seen as a positive thing and this was shown in schools where for instance pupils learnt about different religions and cultures and on the streets where festivals of all faiths were celebrated. Furthermore, many migrants are now a transnational community; as a result of the rapidly changing pace of science and technology, they are part of the virtual environment (Foresight Future Identities, 2013), forging new identities in that dynamic space. Mobile technology and the internet enable migrants to remain connected with their countries of origin.

One of the observations made during the field work was that current migrants are more diverse than ever before; while there are refugees from war torn countries, some of the migrants are professionals arriving in England with pre arranged jobs. Some others are vocationally trained such as electricians, plumbers, builders, chefs, nurses and several other skilled workers. Often their spouses are equally qualified or have basic educational qualifications to find a job which may or may not be the one of their choice, but willing to take as a starting point. For such migrants, home is only a 'flight' away. Hence the story of current migrants is varied. However over three decades ago the conditions for the first generation Bangladeshi women were different.

In the past and to some extent even now, the story of migrants has been about managing adversity and obstacles in order to survive in the new home. Transnational migrants seem to adopt a lifestyle which can be described as the best of both worlds. In the process of this adaptation, migrant women substitute available material to create a home. Food is one of the main items

of comfort in that home. For many migrants, nostalgic memories of food are a trigger that motivates them to search and reproduce the staple or familiar food of the home they left behind. In his study with Bengali Americans, Ray (2004) points out that nostalgia is an emotion and attitude central to food ways among Bengali Americans with food serving the function of evoking a past homeland.

During the field work, in addition to the traditional Bangladeshi food, there were opportunities to taste a variety of European food prepared in a hybridised style. This included pasta prepared with Bangladeshi spices and sandwiches filled with curried potatoes and vegetables, which are popular dishes among adult Bangladeshis as well as among their children. Such practices which involve incorporating new food elements to traditional recipes, have been noted by other researchers (Valianatos and Raine, 2008) while investigating food habits among immigrant communities. For example, in their study (2008: 368) with immigrant women they show how the 'Indian pizza' was created by South Asian women with homemade dough, without the use of eggs but with various types of toppings, sauces, and spices that they modified to suit the palates of the immigrants.

The importance of creation of 'home' will be discussed later under 'Sylhetisation'. For the early Bangladeshis who had migrated to London this was a difficult task because ethnic food and goods were then scarce. It was interesting to note that paan was one of the items not available to the early settlers. Given the length of time women had been without paan, at least over

10-20 years since their arrival, it was enlightening to explore how they started to chew paan in the first place.

Nostalgic memories seemed to be a vehicle to transfer and transport their stories (they were aware of the research aims) to those who would listen. They also used these memories as a tool to bind various experiences, sometimes in the form of stories in an attempt to convey a holistic picture of their past feelings of homesickness and the way they missed the familiar sights of their village, the river, home garden, weather, space and family. Nostalgic memories unfolded the stories of their experiences of childhood, hardships of migration, motherhood and creating a home, and their use of paan, was embedded in this complex biographical narrative. Research in to these biographies rests on a view of individuals as creators of meanings which form the basis of their everyday lives. Individuals act according to meanings through which they make sense of social existence (Denzin and Lincoln, 2000; Roberts, 2002). Hence, paying attention to biographical narratives is important in understanding addiction as a chronic condition. This approach stresses the biographical and cultural contexts in which illness arises and is borne by individuals. As Williams (1993) emphasises, the need to understand illness in terms of the patients own interpretation, of its onset, the course of its progress and the potential of the treatment for the condition, all of which are relevant in understanding paan addiction. The first notion that emerged through their nostalgic memories was ‘missing home’.

Missing home

> In my village everybody know everyone … so you just go to friends' place, I mean their homes … when we go to bath … in the river I go to friends' house on the way ... anytime you can visit friends … we have a good time ... here when I came it is different ... you can't just go to your friend's house … we have to telephone and ask if it is okay (Jessi 63).

Many of the respondents talked about the river, and the space. The loss of freedom, that the new space was not open to them worried them. More than half the study sample talked about the weather in England as being cold and dark. They were not confident enough to go out on their own, for a very long period. In a way, they felt trapped and helpless. Loneliness made them think about the family they had left behind, so they cried.

> My house in Bangladesh is big and the garden also very big … very free ..can walk and bath … bath in river … in London I sit in small house ... Can't go out very dark outside ... I came in December and very cold ... so I cry all the time ... and think of my sisters and brothers … so I think of family and cry …" (Kadija 53)

The respondents associated space with the weather and both together kept them confined to their 'little houses' as they interpreted, and they felt lonely. All the respondents said that they wept when they arrived:

> When I came ... thought this is not lucky. I was happy at home. It is cold, no one to talk, I mean can't go out to other houses people stay inside always ... so no one to talk ... it's bad ... my heart was going very

> fast and can't eat or sleep ... I want to run away ... home run away to my mother and cry... you know I ... Cry everyday ... look silly now (Bibi 60).

In summary, the women felt that the new space was socially closed to them, it was cold and hostile, they were alone and making this new space home must have appeared very challenging. Furthermore, missing home was not the only problem the women had; there were other concerns for Kadija, Bibi and other respondents too. Getting used to marital life in a new environment was an additional challenge.

Getting used to marital life

The majority of the sample (25/30) did not know their husbands well. This was because after their marriage, it took a while for the wives to join their spouses in England. Until then, they lived with the in-laws in Bangladesh. Having arrived in Britain, getting used to living with a man whom they did not know well and also adjusting to a totally new way of life and living indoors most of the time, was not easy. The following extract is not exclusive. It was a similar pattern that emerged in their narratives.

> I got married very early … I was only 14 years. I saw him only one time. Then I went to live with my husband's family. After one week he went to England and I stayed in his house. I was upset because I don't know his family and I don't know him well, only short time. It was difficult ... Because it is a big family ... Everybody ask me to do this and that and I was scared if they tell my parents I am no good …so I did everything ... but it is very hard. No one to tell … My husband gone to

> England I only saw him one time before we married … after 2 years one day his friend came home and told me that I will go to my husband soon … so got passport and everything soon and came to London (Jezima 58)

Getting married to an unknown person chosen by one's parents is not a new phenomenon. All the participants agreed that men preferred brides from home so that they would help keep their traditions. Sumaya pointed out bluntly, "because they wanted to live like in Bangladesh, speak Sylheti, cook Bangla food and women will listen." There is a general belief among men including South Asian men that South Asian women are submissive and as such they are good home makers and their place is home. Even the academic literature on South Asian women, as Ramji (2003: 228) points out, views them as being consigned either to low-status employment or to their reproductive roles, perpetuating their status as victims, concentrating on the negative experiences of low-status employment, and home work.

It has also been pointed out that both colonialists and the nationalists of the colonised have attempted to secure female emancipation and liberation through a series of reforms that would ostensibly rescue women from the oppressive practices of Indian culture (Bhatia, 2003). Bhatia points out that while the colonialists constructed Indian women as exotic yet oppressed, the nationalists assigned the dubious honour of carrying the traditional values of home. In both, Women's subordination was maintained. It is unsurprising that the opportunity of moving into a developed country seems attractive to women. This is echoed in the women's narratives. All the participants in this

study have gone through arranged marriages. The majority of them (26/30) reported the uncertainty and the anxieties they had at the beginning of their marriage. The following account typifies Bangladeshi women's general point of view:

> When I came I was scared, I did not know my husband a lot ... I saw him on the wedding day and then after week he went to England, then it took eighteen months ... yes I think ... for me to come, I was lucky … others wait three four years ... sometimes ... I was lucky ... but when I came I thought ... this is prison ... You know people there think ... going to London is a big thing, I mean lucky they say (Bibi 60).

Although the times have changed now in that the children of these women may choose their spouses, it was different then. The women in the study got married to the men of their parents' choice. Nevertheless, the majority of the sample (26/30) now preferred their daughters to be given the choice of selecting a partner. In the study of Phillipson et al (2003; 47) with Bangladeshi women who were younger than the sample of the current study, only over one third of the women felt it was reasonable for people to choose their own partners. However, eleven years on from the aforementioned study, the attitudes towards marriage among the women in the current study seem to be different.

According to their narratives, the majority of their marriages worked without any problems. However, there were five women in the sample who were separated from their husbands due to various reasons such as domestic violence, alcohol addiction and divorce. These women had to reassess their

gender roles as well as other responsibilities in order to raise their families without the support of the extended family they may have had if they had not migrated to a new country. On the contrary it can be argued that under these circumstances many women will reassess their gender roles regardless of their ethnicity or social class. This study has highlighted that gender roles of Bangladeshi women are not fixed and they are able to change and adapt their roles according to the circumstances. Kabeer's (2000) investigations with two groups of women in Dhaka and London illustrates that Bangladeshi women have preferences regarding where they work. In her study, women in Dhaka worked in garment factories, whereas in London women preferred to work from home as machinists. Nevertheless their contribution to the clothing industry was never acknowledged because they worked from home. As Kabeer further contends (2000: 14), the silence on the situation of Bangladeshi clothing workers in East London by the British labour movement was in marked contrast to the vehemence of their condemnation of the exploitation of Third World women workers abroad. Although the focus here is outside the thesis, it illustrates the ability of Bangladeshi women to adapt their gender roles in order to challenge and survive the hardships of the environment. It should be noted that often powerful stereotypes keep this resilient nature invisible. As Brah (1994: 158) pointed out, within Western discourses, Muslim women in particular are represented as ruthlessly oppressed and in need of liberation.

The five women mentioned above had worked from home and are still involved in some kind of income-generating tasks. Idaya (63) was divorced at the age of 33 with four children. She worked hard to look after her children

and she had not been to Bangladesh till 1997, when her eldest son got married. Describing her situation she recalled:

> My husband went with young woman … its okay …I worked for the factory and earned money ... Council helped me with money and I also stitched blouse skirt ... sari blouse for Bangla women ... my friends and their friends, so I bought things for my children and I send money to my mother and father in Bangladesh.

Not knowing the husband or surviving a divorce are not the only problems they faced. Being unable to speak English, they were confined to staying indoors almost indefinitely. Unlike the present, there were then no English classes for them to attend. Several of them did not even have a television to watch. As such, they did not hear the English language. This concern is seen to have recurred in every interview. Arriving in London without English language skills was the most daunting aspect of their first experiences in a new and unfamiliar country.

Arriving in Britain/ Language problems

The majority of the Bangladeshi women in the study sample started arriving from Sylhet in the 1970s. None of the women in the study sample could speak or understand English when they arrived in Tower Hamlets. Having left Bangladesh for the first time, Sumaya travelled in a plane, she had never experienced this before. As she spoke, her entire experience – the totally unknown mode of travel by air, the long waiting time, the unfamiliar food and language and all the uncertainty – became evident with all its scary details:

> I came with two children one 5 and the other 3. My husband came to airport but inside I was alone with children. I saw another Bangladeshi woman with a child in my plane and I ran to her when we came out of plane. I told her I can't speak English and she told not to worry. When we got to passport place she talked to them … I look down and came out … my husband was waiting and I was very happy. That lady said I am now with my husband and not to worry. Then she went. I never saw her again … I am sad ... I don't know her address or name or anything. She must be old like me now (Sumaya 62).

Lack of English language skills is a drawback for many recent and not-so-recent immigrants. In addition, the weather, the atmosphere, the people and the whole culture of the host country was different. As Kabeer (2000) highlighted, the normal process of transition involved in international migration is made immeasurably more difficult by the shock of contrast between the two different cultural milieus. As a result, the women who arrived without any English language skills, found it even harder because they had to depend on their husbands for everything, including mundane tasks like talking to the milkman. Bangladeshi women had to depend on their husbands to accompany them wherever they had to go, increasing the inequality within this relationship. Attending clinics, meeting teachers, going shopping or even for making a simple journey to the post office was a problem for them. Bangladeshi men worked long hours and the women were not able to do their shopping on their own. They were scared to step out without their husbands or someone who, unlike them, could speak English.

> I can't speak English when I came, I can't go out because I was scared someone talks to me … what to say? What to do? Evening my husband come home and I am very happy ... I tell him I want to go out with him … but he is tired ... He tells me ... Too late now, we go in the weekend. I feel sorry … he is doing very hard work. But weekend he has another job and no time to talk to him ... I was scared to ask everyday about going out because I thought he get angry because he lot older than me (Jezima 58).

It is, however, to their credit that over the years, the women in the study group have acquired a reasonable knowledge of English by attending English language classes and also by learning from their own children. This does not mean that all Bangladeshi women of this age group are able to converse in English. It should be reiterated that being able to interview in English is a selection criterion for the study sample. Therefore, this group of women, either through their own efforts or by taking advantage of some favourable circumstances, had learned English and their views and opinions may, therefore, be different from those who do not or did not have the opportunities or the drive to attend English Language classes.

Within the language classes that have become popular over the last two decades, these women formed groups and supported each other. As the paan habit is a more recent one, they did not chew paan at that time. What is evident about this group of women is that they are more assertive than many of the other Bangladeshi women, encountered during the field work. They are aware of the problems and of the transition that Tower Hamlets has

undergone over the years. During the process of settling down in their new environment, Bangladeshi women had gone through difficult times especially while facing hostilities similar to those encountered by other migrants (Irish & Jewish) who had arrived in Tower Hamlets earlier (see chapter four). However, as described earlier in the thesis, Bangladeshi women are now able to reflect without resentment on how circumstances were on their arrival in England, and the way changes have taken place in their lives as well as in Tower Hamlets.

Hostilities and achievements

The problems of racism in Tower Hamlets during the time of the arrival of the Bangladeshi women, was discussed in chapter four. While socioeconomic status (SES) accounts for much of the observed racial disparities in health, racial differences often persist even at equivalent levels of SES; residence in poor neighbourhoods, racial bias in medical care, the stress of experiences of discrimination and the acceptance of the societal stigma of inferiority can have detrimental consequences for health (Williams, 1999). This can also lead to feelings of helplessness. When they had first arrived in Tower Hamlets, Bangladeshi women did not feel comfortable in their new home. As much as they suffered from the separation of being away from the family they had left behind, there was also some hostility from the host community. It has been noted that in the late 1970s, Bangladeshis were housed in problem estates where they were harassed by local youth, but the police and local authority ignored their grievances (Gardener, 1990).

All the respondents talked about Altab Ali and other victims of racial violence, (discussed earlier in chapter four). The women remembered the incidents vividly and their interpretations are interesting and detailed.

> Those days Bangla people can't go alone, White boys are everywhere, they sometime spit when you pass them … but you know they don't know what they doing may be mothers don't know what they doing … old people are OK it's only some boys … did bad things I mean ... But now it is over and I go everywhere alone … my husband like to stay home ... Whitechapel is good now and Banglalog (Bengali people) everywhere so I am not scared … nice place now I like it (Nusrat 59).

> When my children was young I was scared something will happen to them … I think of all bad things and when they come from school I am happy. We can't go out to park I was scared. My husband come home after work and sometime tell me they (White boys) are in the park, where are the children ... I tell him children at home ... but now… park is full ... Bangla children everywhere … not scared ... this is a good place to live (Akil 66).

The narratives demonstrated that the transformation between the beginning of their time in the UK and the present is huge – both for the community and for the individuals involved. They have created a place that is their own. All the respondents agreed that Tower Hamlets is a friendly place now and they do not intend to return to Sylhet.

> Now it is different ... see … not like those days ... you go out ... buy your things ... Like..... ..anything ... Bangla people everywhere ... so many ... like in Sylhet ... I mean better than ... because they have all in one shop but it was different when I came, I was sad and cried so much I want to go back my husband was angry and tell me ... You want to go ... go then .... Now they have everything. When my daughter in law came I went to Whitechapel and show her everything ... you see we are here so she is ok, but I have no body when I came here... (Bibi 60).

Bibi stated that she had no regrets about coming to England. Her children are well educated and she is now helping her daughter with childcare. She still sews for her friends and enjoys Bangla television and chewing paan. When asked if she started paan when she was sad, she laughed and said that even in the 1980s when the children were small she never bought paan because it was not easy to find paan in Tower Hamlets. Unlike the present day, paan was then considered a luxury item, which only a person returning from Bangladesh would bring and share among their friends and relatives. That too was rare because most Bangladeshi people could not afford a holiday in the 1970s. However, the circumstances have changed for these women who are older now and their burdens and problems are relatively less than before. This is mainly due to the reduction of parental responsibilities; their children are now educated and employed. Women's discourses indicated that their children are better educated and they feel less anxious about their children's future.

As for the women, paan is not a luxury item anymore; it is now an essential component of their daily events. While meeting friends, during a Koran class or even at home while attending to domestic tasks or relaxing, paan provides a comfort of recreation. However, it is not an ordinary activity of recreation alone; as discussed before it is an addiction for tobacco and areca nut. Although ambivalent about their own use of paan, the women in the study appreciate the availability of Bangladeshi goods in their neighbourhood, which has helped them to create home in a very Sylheti way. Similarly paan is available and they buy the ingredients of paan in large quantities. Although in their narratives they complained about paan being available (see next section) they seem to like the idea of ready availability. Now that the outside world has become less hostile and more familiar to them, their own social world, their circle of friendships and family has expanded and their ability to fulfil their role of creating the comfort of home, has transformed the lives of their families. Nevertheless, paan use is a concern mainly due to their awareness for the potential threat of cancer.

Paan was not a problem then/availability

According to their narratives, Bangladeshi women did not start chewing paan as a coping mechanism although they had nostalgic memories of paan and other material objects they left behind when they left Sylhet. Paan was not readily available (in comparison with the availability at present) at the time of their arrival in the seventies and early eighties; even the other commodities such as rice and Bangladeshi fish were scarce. Fouzia came to England earlier than the others and she had lived in the East End over the last four

decades. The first thing she talked about during the interview was about her paan use. She said:

> I came when ... I think ….it is long time now forty-five years, I was young and paan is not there then, very difficult to find not like now … I never ate then, but my uncle's old friends come home in the evening and they bring paan sometimes and give me also. When I was child I din't eat it, only my grandmother (Fouzia 65).

Fouzia made a valid point that in their childhood in Bangladesh, paan use was associated with older people. Other respondents were also of the same view. One of them had the following to say:

> I never ate paan like this when I came here … maybe sometimes at home ... when I make one for my Nani (grandmother). She has no teeth. I chop paan for her ... Put everything and chop, chop and give her … if anything too much I put in mouth … I don't like it … but you know … don't want to throw ... so I eat ... after while … yet after I wash nicely my mouth ... You know my tongue is red and I rub it so much … true I don't like it … when I came 1978, no paan in shop … How do I eat? You see no paan then … no one to talk ... I don't know people ... I mean Bangla people ... so I cook … children … clean ... and no paan ... But now paan in every Bangla shop (Rabia 59).

There were not many Asian shops in the 1970s and early 1980s and ethnic commodities were costly. Fouzia clarified that they had paan occasionally in the beginning and it was only in the past 15-20 years, that her use of paan

had become excessive. In biographical terms, paan use is associated or linked with significant periods of the life of the respondents. As children, they had occasionally tasted it and accepted it as a habit of the elderly. As adults, they had not brought the habit with them to the country to which they had migrated, but their circumstances had motivated them towards its use. It is clearly not a biographical constant.

> My husband's friend's wife … you must see her … she eat so much, one day long time now… I went to her house and she asked me to eat ... I ate it you know, because I like her and din't like to say can't … One day she came to my house, she ask where is paan … so I ask my uncle to get paan for us and he brought home paan … I start like this and now … (Nisha 60).

It was interesting to note the way Nisha, stated that her paan use was much less when compared with that of her friend. Every respondent of the study was able to give a detailed description about where and when, and the way they started chewing paan after arriving in England. The data confirmed that the majority of the women in the sample felt that paan was not available when they arrived, but the circumstances such as its availability, motivated them to use paan in the first place when it became freely available in Tower Hamlets. It was introduced into domestic private settings by significant others, a social aspect that later became an aspect of relaxation in friendly social settings during visiting each other or attending Koran classes. Enjoying a paan quid became a symbol of friendship and a social ritual. When paan became freely available in Tower Hamlets, women's use of paan became more regular.

Gradually, Bangladeshi food and other commodities filled the markets of the East End. They were comparatively cheaper and affordable. These commodities helped Bangladeshi women to create home with familiar material goods. As the external environment changed, their homes demonstrated their re-creation of security, reflecting the aspects of hybrid cultures that they had woven together and shaped.

'Sylhetisation'/creating home

Bangladeshi migration in to Tower Hamlets has followed a similar pattern to elsewhere in England. Parallel to all transnational migrants Bangladeshis move and create home in the places they settle in. Vertovec (1999: 451) has described transnational migration as a type of cultural reproduction; it is often associated with a fluidity of constructed styles, social institutions and everyday practices. In the past, cultural reproduction took place at a slower and smaller scale, however, present transnationalism has been shaped by the increasing advancement of technology. Air travel, emails and other types of telecommunications have helped migrant communities to maintain regular contacts with home countries. Over the past few decades, Tower Hamlets has undergone immense demographic changes and cultural reproduction can be seen as one of the transitions. This kind of transformation is not a new concept; it is possible to make parallels with the transformation of some neighbourhoods in Leicester. However there are differences in the background of these migrants who came from Africa as many of them arrived with entrepreneurial abilities, a good education and skills. As a result they adapted easily to the local economy by establishing a successful Asian

business sector (Vertovec, 1994). According to Law and Haq (2007: 58) who recorded the oral histories of migrant experiences, derelict areas were taken over by the Asians because they were cheap and gradually the mainstream shops disappeared from Belgrave Road. Similar effects can be seen in cities such as Birmingham, Manchester, and Bradford where other South Asian groups have settled down. Hence the transformation in Tower Hamlets has many similarities and differences with other cities that have attracted migrant communities

The transformation that took place over the years was not a smooth transition. In a diverse community there are bound to be conflicts and changes. In addition to the problems discussed in chapter four, within the Sylheti community there seem to be conflicts and misunderstandings. For example there are organised groups according to different allegiances that engage in endless rivalry with each other (Eade and Garbin, 2006). There are other groups representing different political parties here in England and in Bangladesh. These differences reflect the characteristics of any community. Communities are dynamic in nature; they depict matters related to inclusion and exclusion, identity and belonging, similarity and differences (Delanty, 2003). Nevertheless communities offer support and security; as Silk (1999: 6) suggests, communities infer “common needs and goals, a sense of the common good, shared lives, culture and views of the world, and collective action”. Within these differences and similarities the community thrives.

One of the most important issues raised by women is that language is not a barrier for Sylheti women as it used to be.

The pharmacist, the general practitioner, shop keeper, community worker and even some postmen spoke Sylheti. The local Koran class, the English class and the physical exercise class were no different. In schools, Bengali workers and teachers were there to speak to Bangladeshi mothers. The Sylheti language was written on all the signposts in the hospital, the dental institute and in GP surgeries. Language was not a barrier for those who did not speak English fluently; the observation made during the field work was that the second and third generation Bangladeshi people, who are fluently bi-lingual, work as link workers and translators.

The environment depicts the prominence of Bangladeshi culture in terms of people, materials and commodities, and celebrations and festivals such as Bengali New Year. A classic example of culturally oriented marketing is on display alongside the main streets of Whitechapel and Bethnal Green; a vendor said that in Tower Hamlets, it is possible to purchase almost anything and even more than what is available in a marketplace in Sylhet. “You name it I will get it for you within an hour”, he added. This is researcher’s interpretation of ‘Sylhetisation’. It is a positive sign of hybridisation between the dynamic cultures of Sylhet and cosmopolitan East London; somewhat similar to what Robertson (1995: 30) described as ‘glocalisation’ – a process which involves the reconstruction, in a sense the production of home, community and locality. The maintenance of some sort of cultural continuity have been studied by several authors; for example Brah (1996: 18) points out that cultures are never static and cultural reproduction is, in part, a cultural transformation. Furthermore, to call on Brah’s notion of homing desire when discussing the places of belonging amongst Italians in London, it is about the

construction of a place of belonging through cultural practices; it is about the desire for home and belonging. Sylhetisation can be considered as a form of cultural transformation brought about by such homing desires of Sylheti people. The term Sylhet, rather than Bangladesh, is used in coining the term 'Sylhetisation' for the reason that the majority of the Bangladeshi people in Britain, or for that matter in East London, have originated from Sylhet, as cited earlier (Adam,1987) (see also Eade,1989). It is based on the inferences derived from the experiences of fieldwork and interviews. It indicates the way the transformation of wider social space has been linked to the transformation of women's lives – as they have constructed social lives and homes they have been a dynamic aspect of the wider change. The term is useful in describing:

- how the features of 'Sylhetisation' have influenced Bangladeshi women in the study sample, in creating home and also providing a comfortable environment with social support,

- the role played in providing a space which is conducive to starting and continuing paan use despite the known health risks, perhaps the health risks would not be known to them at that time.

Field work provided the opportunity to observe women while shadowing them in their day's routine. The majority of them (26/30) grew vegetables such as pumpkins, bitter gourd, long beans, coriander, green chillies and aubergines. Some women who did not have access to a garden had their vegetables planted in pots which are placed either on the kitchen windowsill or in the

balcony. Describing her green chillies, Shipa said that she had them in her garden in Sylhet:

> My mother grow green chillies at home … they have different chillies, small and big ... we don't buy chillies … but in this house no garden and I can't grow … I like to grow … I help my mother when I was little … everybody know how to grow but no place … I can buy this in Whitechapel … But my chillies are better (Shipa 59).

Shipa felt that although she did not have a garden, she can still make the familiar vegetables of Sylhet at home. She had another vegetable, marrow, planted in another big pot in the balcony along with tomatoes and aubergines. "I have all this like in Sylhet," she said proudly. Creating home and Sylhet seems parallel. She grows and cooks familiar vegetables such as marrow which can also be bought in the local market. As Valianatos and Raine (2008: 356) point out: "the importance of traditional cuisine and foods rests not only in their physical attributes, but in how these foods satisfy emotional needs. They serve to connect with one and to recall the foods, tastes and people of home". This was evident all around. In the kitchens of Bangladeshi women, the fruit bowls were full of fruits from Sylhet. Outside, on the streets of the East End, it was possible to visit a variety of Bangladeshi shops with women for buying different Sylheti commodities including necessary ingredients for cooking and for preparing paan. In this highly 'Sylhetised' home, paan not only reflected domestic rituals of host/guest, one where they could show their taste to good effect, it also recreated sensual familiarity and comfort.

Despite the negative image attached to the paan use as a health risk and a sign of backwardness their own choice to bring this aspect of Sylhet into their home, demonstrates that paan is part of a positive identity in this setting**.**

Incorporating Sylhet features in Whitechapel

The study participants adored the atmosphere in Whitechapel. “It is like home”, was their popular phrase. For some, it seemed even better than home. For instance, Rabia, one of the respondents, told me that in Sylhet she could not buy everything at one place, but in Whitechapel it was possible to do so. Explaining this, she said:

> Back home if you want to buy fish you go to fish market and vegetables we buy in the village. Then I want sari then another place … you go to ... and to buy bread you go another place, here … you can buy all in Whitechapel. You can tell the price you want and bargain like we do in Bangladesh … in the morning everything is new ... I like to go in the morning ... then I have all the time to choose … I like yam ... you know ‘Mura’ (a yam)… it is very good ... I mean health good for health ... yeah … very good (Rabia 59).

Miller (2008) in his study into the lives, loves and domestic interiors of a household in a London street, pointed out the way material things function as a vehicle for social interactions. This can be seen in the streets of Whitechapel as well as in Bangladeshi households, although, unlike in his investigation, ‘the tribe’ in the current study was visible in the streets of Tower

Hamlets. It was “a culture, a neighbourhood and a community”, as opposed to the London Street where he carried out the investigations.

Outwardly, the material culture of Bangladeshi goods and sounds (language and music) created a Sylheti atmosphere within the culturally diverse city of London –the material world of Bangladeshi women is situated in this wider context, partly in their homes and also in the immediate environment of Tower Hamlets. Paan is just one small, but very important commodity that was available in this material world of Bangladeshi women.

The people of Bangladeshi origin have contributed to the transition in Tower Hamlets. It is a process that has happened over the years as a result of the influx of Sylheti immigrants from Bangladesh to East London. Their influence can be seen not only in the streets, but all over the borough of Tower Hamlets. As mentioned earlier, Brick Lane is a fine example of a space characterised by the presence of the Bangladeshi community and the assets of this community. In a study that explored the construction and contestation of meanings around the iconic East London street of Brick Lane, Alexander (2011) highlighted the sense of community and belonging that emerges around the idea of Brick Lane as the ‘cultural heartland’ of the British Bangladeshi community. This is not just a transformation of place but a transformation of homes and societies, something which women participated in, creating homes, educating children and acting as carers.

Caring role of women

Earlier studies with Bangladeshi women (Phillipson et al, 2003) have highlighted that the majority of them have responsibilities for older spouses

and children. This is unavoidable due to the extended family living in the same house. There are advantages and disadvantages within an extended family. When questioned about how they see the childcare role, they did not complain, but showed empathy.

> My daughter work in the hospital … she is a nurse … sometime in the morning and sometime in the night she work ... Salim (son-in-law) work in restaurant, he is busy ... I have to take Fias to school ... My husband keep eye on baby ... if I am late he worry too much. I come home and cook and wash the cloths sometime iron cloths … When my daughter at home she take Fias to school … Baby is 2 years and he want me all the time … I can't go out because the children (Mukulika 64).

Mukulika represents Bangladeshi women who are carers. Throughout their adult life, they have been in a caring role. She had six children and bringing them up, according to her, was not easy. She now lives with her youngest daughter and the other children have moved out after marriage. Her caring role had continued while she was a mother to her six children and even after she had become the grandmother of many of her grandchildren. Two of her sons live nearby and her grandchildren often visited her. Her husband is 79 years old, but seemed physically much older. She did not complain about her role, but she looked busy and tired during the researcher's visits.

Mukulika and other respondents believe that it is a woman's duty to help her family. That is what their mothers and grandmothers did, so now it is their turn to take on the role. In the process of helping their extended families, they offer unconditional help and support to their kin and try to fulfil their caring role

to the maximum extent. Oakley's work (1975) with housewives has highlighted that housework and caring for children were exploitative and oppressed the women. Her analysis of the housewife's role as alienating and leading to isolation is supported by other feminist writers (Brickell, 2011) and it reflects changing social attitudes towards housework. Brickell argues that the persistence of intra-household inequality is widely regarded as a 'stubborn stain' on development achievements and aspirations (2011: 1353). Barker (2008: 2) contends, 'promoting equal responsibilities between men and women in care giving is at the heart of one of the most challenging and lingering aspects of gender inequality'.

Oakley's sample of women was younger (20 - 30 years of age) when compared with the sample of Bangladeshi women (50+ years) and the study was carried out in the early 1970s. Nevertheless, it is evident that despite the differences between the two samples, in terms of age, culture and times of investigations, there are similarities in the way housework and caring for the family, place a burden on women. This notion is supported by a recent study (Alyaemni et al, 2013) which explored gender inequality in health among Saudi Women and highlighted that the majority of women perceived their health to be worse than men's and attributed this to their gender roles including care giving roles. However, despite the stress and pressure of work felt by the Bangladeshi women in the study sample, they also valued and acknowledged that in the long term their caring role is crucial for the welfare and wellbeing of the family. At the same time, the same isolation and stresses pushed them to use tobacco which gives them a better feeling. Although there was a tone of melancholy in their voices at times, they were clear in

what they meant. It was not missing home or Bangladesh. For the women in the study sample returning to Bangladesh was not an option:

> I don't want to go back … but I like to meet friends and visit old friends … I like to work in an office or shop may be … working at home is very boring (Rani 63).

> Sometimes I feel lonely because I feel that I have wasted my time here. I was going to be teacher before I came ... but everything change ... I have to come ... but I don't want to go back … at least my children get proper education (Rubi 59).

The women presented different reasons for their feeling of discontentment. Although I have not explored this area of mental wellbeing, other researchers (Pollen, 2002; Phillipson et al 2003) have highlighted the isolation felt by Bangladeshi women as carers. This is important as it can affect their general health. Psychological wellbeing is a determining factor in health. In a study investigating patterns and predictors of tobacco consumption, Graham and Der (1999) reported that in addition to socio-economic factors of the marginalised groups, poor psychological health was found to be the single most powerful predictor of high rates of tobacco consumption. Therefore, understanding issues related to segregation, caring roles and feelings of isolation are issues that need to be taken in to account when designing and delivering health promotional activities for this population. Similarly, understanding their attitudes, aspirations and expectations could transform the way health professionals think and work with this population of women. The life experiences of these older women have changed their views and

opinions as well as attitudes towards traditions and modern ways of life. Furthermore their narratives highlighted the way in which the women of this generation were focused inwards towards the family, making a home. In this they were successful, as is in evidence in the very different lives of the younger generation.

The younger generation

The children of the study group and their contemporaries have grown up in a socio culturally different Britain, and in a different Bangladeshi community, to that initially experienced by their parents, who were the first generation of Bangladeshi people in Britain. It has been reported that over 40% of the Bangladeshi population was under 15 in 2001 and currently they form a large cohort of British Bangladeshis who were either born or primarily raised in Britain rather than migrating from Sylhet as adults (Phillipson et al, 2003). Meanwhile more recent economic migrants such as doctors and other professionals come from a different Bangladesh to that of the 1950s to 1970s, where, as Gardener (1995) pointed out, the rewards of migration are evident in the wealth of elite Londoni families. Furthermore, it has been shown that educational achievements of young Bangladeshis in Britain remain highly dynamic with dramatic reductions in the percentage of 16-24 year olds without qualifications relative to older cohorts (Modood, 2005). In recent years younger Bangladeshi generations have entered higher education; by 2001 their representation among university students has matched the general population (Dale et al, 2002). Meanwhile, admissions to higher education institutes indicate that educational inequalities among younger generations

are not strongly based on their parents' occupational class (Modood, 2005). It has been highlighted that parental emphasis on the value of education and the contribution of relatives as positive role models have led to this educational achievement (Phillipson et al, 2003). The respondents felt that despite the problems they encountered, present Tower Hamlets provides opportunities for their children.

British-born Bangladeshi youth are employed in local councils in London. They are not only involved in local politics, but also influence Bangladeshi political parties from England. It has been reported that most of these second generation political activists were born during the early 1960s and came to Britain in the mid-1970s (Eade & Garbin, 2006). During their time in Sylhet, they experienced the 1971 war and in the streets and schools of the East End there was discrimination (Garbin, 2004). However, they had been resilient, gone through education and been actively involved in the work of local authorities, including health and social services. There are a number of second generation teachers, social workers, doctors, community organisers and voluntary sector workers in Tower Hamlets. Thus, the human resources as well as materials from Sylhet have enhanced the Sylheti identity in Tower Hamlets. Furthermore it is important to note the relationship between the generations; the women in the study sample have made it all possible for younger generations to move up on the social ladder through education, yet have stayed in the background. The way they moved into the emerging Sylheti space in many ways reinforced the boundaries that excluded/protected them.

Effects of sylhetisation

Despite the initial difficulties and stresses, and other hardships they had gone through, the women in this study are positive and optimistic. The majority of the Bangladeshi residents in Tower Hamlets feel that the changes that have taken place over the years are beneficial to them. The women do not feel scared to go out without English language skills. Bangladeshi women, who came to Tower Hamlets in the 1980s, did not have this experience and they had to adjust to the new environment. However, on reflection they felt that their circumstances had changed. They are older now and they do not feel the same as they did upon their arrival in England. They now play the role of mentors to the new brides who are arriving from Sylhet or other parts of Bangladesh. Amu who has lived in Tower Hamlets for 30 years and whose son got married to a girl from her village speaks thus:

> When my daughter-in-law came I showed her Whitechapel … She can't believe … she told me this is not like London ... Sylhetis so much ... I show her everything and she is very happy. I show her place to go for English class … (Amu 65).

Amu is positive that her daughter-in-law will learn English soon and educate her grandchildren well. While members of the older generation are now enjoying the results of their hard work of creating a home for their children, as Phillipson et al (2004) point out, the young Bangladeshis educated locally – at college or in the university – are likely to stay and add to the stock of facilities and amenities in the locality.

‘Sylhetisation’ on the whole, has had a positive effect on the Bangladeshi women interviewed. It has been beneficial in terms of their social and emotional welfare and emancipation. As they pointed out to me, surrounded by their countrymen, they felt much secure and they are able to walk about in their traditional clothes when attending English classes, hospital appointments or shopping for the commodities of their choice. Unlike in the past, they do not have to depend on their husbands. They go out on their own or with friends. ‘Sylhetisation’ has helped them overcome their initial feelings of being homesick. They have created ‘home’ and an environment which is conducive to their children’s education and wellbeing. Within this environment, paan is abundant along with other Bangladeshi commodities.

‘Sylhetisation’ though helpful to Bangladeshi women in terms of networking and support, has also encouraged paan use. The women’s growing social circle provided ample opportunities to use paan. Socialising started with a cup of tea followed by paan. However, it should be noted that, as described in an earlier chapter, even when they are not socialising, they chew paan at home. Forming their own social networks meant that they did not have the opportunity or the need to socialise with the rest of the community. According to their understanding, when their children were younger, the mothers became friends. Some of them are relatives. They formed groups and remained friends for a very long time. Some of them are still in contact with each other while others have moved away with their children. They pointed out that this is the reason why they did not interact with others outside their social circles. It was not a deliberate act on their part; there was no need to spend time with other communities. Even within the Bangladeshi community they formed

small groups and socialised within them. Within these groups paan chewing was accepted and encouraged and the majority of the group members are addicted to paan. Hence here their identity is marked by paan use; this makes their position as 'outside' or as backward as symbolised by the paan use.

As discussed earlier, paan use (chewing) has a certain amount of stigma attached to it and as such the younger generation does not approve of it. Furthermore these women may be regarded as old fashioned and traditional. Referring to the bodies of women, Puwar (2003: 259) points out, that ideas about "third world difference" are marked by a paternalistic attitude towards women. Within this difference "third-world women as a group are automatically and necessarily defined as: religious (read 'not progressive'), family-oriented (read 'traditional'), legal minors (read 'they are-still-not-conscious-of-their rights'), illiterate (read 'ignorant'), domestic (read 'backward'), and sometimes revolutionary (read 'their-country is-in-a-state-of-war; they-must-fight!)" (Mohanty, 1988: 80). Bangladeshi women's paan use may be seen as part of their backward nature as discussed earlier when referring to the comments of general practitioners on women's paan use. The physical visual effects of paan use mark them visually as not only older, but as 'traditional' compared to younger women/educated women.

Despite the paan addiction, as demonstrated by the progress made by first generation Bangladeshi women who did not speak or understand the English language at the time of their immigration to Britain, they are now able to relate and articulate their stories to a researcher in English. Nevertheless, considering their resilient nature and their achievements, Bangladeshi

women's participation in the wider social context seems to be lacking at present. This may appear inconsistent with the level of self-empowerment which the study sample acted and lived. However, It is not possible for people to be empowered in all aspects of decision making. Empowerment is a multilevel process involving changes in intrapersonal, interpersonal and socio-political relations (Wallerstein, 1992). These changes need to happen simultaneously over a period of time. It also seems to arise from activities that promote peoples' participation in a variety of social actions that increase their individual and collective (community) capacities to change health-determining conditions (Duignan et al, 2003). Paan addiction is a health determining situation where the women in the study sample are concerned, but unable to act upon. As Rissel (1994) pointed out, empowerment processes are a progression along a dynamic continuum of action from individual and small group development to community organizations, partnerships and advocacy/ political action. Hence, lack of wider social involvement has grown through their responses to exclusions, responsibilities and challenges.

Lack of wider social involvement

While 'Sylhetisation' of the living space provided social and emotional support and a sense of security for Bangladeshi women, their narratives also indicated a degree of disappointment about their own lives. Feelings such as a sense of loneliness, not being heard or acknowledged, being ignored, being unable to participate in activities with non-Bangladeshi residents and feelings of lack of fulfillment recurred in their narratives. They felt that they are marginalised in the wider community. Most of the research based in Tower Hamlets

(Croucher et al, 2003a, 2003b; Pearson et al, 1999); had categorised the Bangladeshi community as a lesser privileged, lower socio-economic group. As such, the study sample in this research investigation is a marginalised group of people who have become dependent on tobacco due to personal, social and environmental circumstances. Furthermore they seem to feel a sense of shame about their paan addiction.

Understanding the complex sociocultural issues that are contributory to paan is not a straightforward mechanism; nevertheless a crucial component in planning health promotional initiatives. Tabu is a 50 year old machinist and the following is an extract from her long interview:

> For me it is like I have everything because I work ... yeah my two sisters live here, we meet every week at least yeah ... and our children meet and go out some times. Yeah ... I know I have a good life here but I don't know ... something ... missing like ... when I meet them we talk about our days in Bangladesh ... yeah, our parents, we did not see father much because he was here and dint come home much but he sent us money ... in the evening I feel lonely like, I don't know why, my children are there my husband is not bad man like other men, he is good but ... I feel lonely and feel like crying sometime, then I eat paan and feel good for a while, like happy yeah… .

Analysis of detailed descriptions of these feelings and their experiences highlighted their concern about a lack of wider social involvement which emerged as a theme associated with paan dependence. The negative feelings were often alleviated by chewing paan, which according to the

majority of the women (17/30), gave them comfort. Bangladeshi women viewed themselves as segregated from the local non-Bangladeshi community. They reported that other than the well-established relationships and social support within their own small social circles, they do not have opportunities to get involved in the wider community and in non-Bangladeshi events. The respondents have a good social network now within their circle of friends and relations without which, they would not have the much-needed support while their children were growing up.

As Gardener (2002: 128) pointed out, 'physical proximity' to other families is an important aspect of Bangladeshi life. This was even more crucial at the beginning, when the women were going through the stresses of migration. Kabeer's (2000) research with Bangladeshi people, highlighted the stresses involved in making the adjustment from a slow-moving, rural society in one of the poorest countries of the world, to the fast-paced urban life in one of the richer ones (2000: 268). The women have survived the harsh realities and hardships of migration and they are now entering old age. Their lives were extremely hard at the beginning, but productive, their children are educated and the habitat has undergone tremendous changes. Their children, the second generation, are now more assertive. As pointed out by Begum & Eade (2005), although Bangladeshis seemed to be marginalised from mainstream society, they are involved in local area politics. For example, during the study period, Lutfar Rahman was elected as the first executive Mayor of Tower Hamlets in October 2010. Although this indicates the political maturity of the Bangladeshi community, for the first generation of Bangladeshi women in the study sample, their world is still small.

The paradoxical nature of the women's situation is that, on the one hand, they feel that they are marginalised in the context of the wider society (school, workplace). On the other hand they have been resilient and successful in some aspects of their life; their children have succeeded, their girls have been educated, they have their own social group and they are valued by their families. As discussed before, similar to many migrants, they have gone through adversities, obstacles and years of hardships. The narratives of the respondents demonstrated a wide variety of complex interactions and dynamic socio-cultural mechanisms they used and continue to use in order to manage differing circumstances in everyday life events. Such mechanisms of roles and relationships between people in a wider sociocultural context generated socially mediated identities such as family relationships, membership of Sylheti community groups, education groups, religious fellowship and attachment to the present home. These shifting identities were a resource for surviving hardships, mediated through networks of social relationships and shared aspirations. Paan use is embedded in this complex social position and the stigma of paan dependence represents the ambiguity of their position. As indicated in their narratives, they would like to stop paan use for the betterment of their appearance and health, but the nature of addiction is such that any attempt to cease paan use has not succeeded to date. Furthermore, paan use gives them comfort and sociability within their own social circle. This sense of belonging and comfort marks both the positive aspects of their domestic role, their strong social role, but their exclusion from the wider world and a new kind of Bangla femininity. This

tends to keep them closer to their smaller social circles segregating them from the wider community.

Segregation and uncertainty

It has been argued (Smith,1989) that segregation is more pronounced in inner-city areas where migrants live. Due to the high level of segregation in urban areas such as East London, where they lived, demographers have noted Bangladeshis to be living as an encapsulated community (Eade et al, 1996). This is however debatable. Nevertheless, following the 2001 violence in Oldham, Burnley and Bradford, between young Muslims, and the police and white young men, the Labour government's analysis (Cantle, 2001) indicated that the segregation is a cause for blocking the development of common identities and values, and cross ethnic contact; therefore the events were symptomatic of tensions within the multicultural areas of Britain.

The Cantle report further emphasised that the way forward is based on contact-based community cohesion. Among the recommendations were promoting active citizens and communities as essential ingredients of social progress. Furthermore, during the Labour government between the years 2001-2010, community cohesion was 'mainstreamed' within wider race equality policy agendas (Home Office, 2005). Meanwhile Alexander (2004) commenting on the implementation of the understandings in government policy papers and practices around 'community cohesion' and 'citizenship', argues that each of these arenas employs very static and bounded notions of 'community', 'culture' and 'identity' which deny the complex formations of lived identities and obscures ongoing relations of power and disadvantage.

Examining the implications of ethnic segregation is beyond the scope of this thesis and considerable research (Finney and Simpson, 2009), has contested the notion that ethnic segregation is negative. Nevertheless it should be noted that the pattern of ethnic minority settlement in Leicester remains highly segregated (Singh, 2003: 46). However, in contrast to the cities such as Oldham, Burnley and Bradford, Leicester seems to have shown racial tolerance and harmony between its communities. The Cantle Report (2001: 15) held up Leicester as offering a model of multicultural cohesion for other cities, identifying areas of good practices.

As for the Bangladeshi women the segregation was helpful at the beginning in terms of security and support. Eade (2010) contends, tight social networks, the pressures of life within London's poor neighbourhoods and the limited opportunities for upward social mobility are encouraging Bangladeshis to remain behind the boundary of a highly encapsulated community. Although the term highly encapsulated is debatable, community life has many advantages; it provides security and belonging. However, as the study found, whether the Bangladeshis are encapsulated is open to question.

The circumstances for the London residents are now different to the period when the study sample arrived in Britain, and the term encapsulated community does not apply to the current Bangladeshi community. They are indeed a community with supportive networks, but they are in a global sense, a transnational community. Although the effects of being a transnational community has broadened the horizons for younger generations, who now travel widely and are more educated than the first generation of Bangladeshis,

it does not make much difference for the lives of first generation mature women. They may benefit from occasional trips abroad to another country, with their children or to Bangladesh to see relatives and have a holiday at the same time. However, the women felt that they could be more useful within the wider community; nevertheless, they have anxieties about how others will react to them as evident in the following excerpt:

> When I go to parents evening, only teachers talk to us. Some mothers are OK but some look at us ... in bad way … I mean no smile like ... I know some of them from other countries … they don't talk to us may be think we can't speak English, … but I can speak better than them … I speak to my children in English sometimes ... These 'gore log' (White people) ... They came now like may be four five years. I know in school they work sometimes. I like to work but they don't ask me ... maybe they think I don't know how to work …if you are white then they get jobs … Our Bangla shops also white girls work, my daughter said they are from another country (Rabia 59).

There were strong views among some women about how others see them as 'incapable of doing a job outside home', and their inability to find jobs even within Bangladeshi owned enterprises. Although some of them have reached the age of retirement, they did not see age as a barrier to become involved in local activities:

> I am old, but I can still work. Not big jobs … but I can work in shops. I can help in school … I see very old people work … you meet people ...

> and it is good … not to get money … but just to do something is good … just sit at home is not good ... I only meet our people (Fatima)

It should be noted that not all the participants were keen to find a paid job. Some felt they could still be of some help to the community. The respondents had time for themselves except for eight respondents (8), who had caring roles and the responsibility of caring for grandchildren and ailing spouses.

Change of attitudes

Bangladeshi women in the study sample felt that their attitudes have changed. Although they are an older group of women, they do not consider retiring or staying at home all day as a positive way of spending the rest of their lives. The majority of the respondents indicated their willingness to be involved in the wider community. Those who wanted to become involved had clear ideas of their areas of preference. One of the examples they gave me was to work with interest groups in the local neighbourhoods. Some of the respondents were aware of local projects. The Women's library in Bethnal Green is another place where people from all walks of life meet and share their interests. There are several local participation groups in various activities related to the environmental projects which the respondents were aware of. Getting involved in such activities can provide them opportunities to meet and work with other residents in the borough. In the case of the respondents of the study, this involvement has not taken place so far. One of the interviewees told me that a visit to the women's library with her daughter was an eye opener for her. She was not aware of the fact that women in Britain had a difficult time, in terms of equality in the past.

> I thought ‘gore log’ (white people) was kind to women ... but my daughter explained to me how they suffered and fought for equal rights ... After going to library ... She said we must fight, not like those days, then I din’t ask anything. You know my daughter is clever (Fouzia 65).

Fouzia showed much enthusiasm about local projects although she is not involved in any. She stated that if others are willing, a group of them could get involved in these outreach projects. She also stressed that they will feel safe if several Bangladeshi women are together. Safety in numbers is an issue of confidence for them. Fouzia’s feelings about the younger generation are reflected in other respondents’ narratives too. When asked how they feel about the future of their daughters, only four respondents thought that the girls had to marry and have children. Others spoke of the importance of education. Zubeda accepted that over the years her attitude to marriage had changed. She believes that women need to be independent. All the women believed that education is the way to women’s freedom and autonomy.

> My eldest daughter married early … she is 18. I know she wants to study … but the boy is good and good job in the council … so I told her it is good to marry….. this now I think different ... second girl went to UEL because Zeema (eldest daughter) told ... not to marry early and finish study … I think it is very good ... she meet a boy in the college and married … I think ... girls must study … they need money … can't ask husband everyday … I ... like children study before marrying … then you have freedom … I like freedom … but my time all girls marry

> soon … so I have to … but in this country you can do lot ... but must study and work (Zubeda 60).

This is symptomatic of the awareness within Bangladeshi women of the changing roles of women and their appreciation of the same. It also echoes the findings of Kabeer's study (2000: 179), in which she reported on Bangladeshi women's views of 'revaluing of girl children and the greater willingness to invest in their daughters' education. Phillipson (2004; 49) pointed out that some Bangladeshi women in their study, voiced frustration with their own lives that made them wish for a better future for their daughters. As Nafiza (63) pointed out:

> Girls have to study... Then go to uni ... You know … only if … then they get good jobs. I don't want my children to do labour jobs, like gore log they must study. Sometimes I see the TV, Bengali people educated. Children have to study … And girls have to ... Otherwise like me they will be at home and cooking and washing and cleaning all the time.

The respondents also made the point that they would like to share their ideas and opinions when decisions are made about their lives and environment. Zara, an assertive interviewee, told me that she has several ideas and opinions about schools and Bangladeshi children:

> People ... I mean big people like R (a local councillor) don't ask us what we like or what we want ... because they are in the town hall and they are Muslim they think and decide ... they think they know but sometime ... I know it is good they doing good for us ... but if they ask us we know

> better to tell sometimes what we want. It is like in the school you have teachers from Dhaka ... They are very proud ... and rude ... if they ask me I will tell them get teachers from Sylhet not from Dhaka it is like that always ... we can tell what to do if they ask sometimes ... Even our children will tell ... Our children have white friends because they work with them. My son works in the town hall and his manager like him a lot. My other children will work when they finish their school. I know they will go to University. My daughter wants to go to Queen Mary (Zara 55).

Bangladeshi women in this study had opinions about their schools and children. It is encouraging to see their eagerness to be involved in consultations of the issues that mattered to them such as schools and teachers. However, it should be acknowledged that although the sample in this study has adequate knowledge of English for conversation, there is a silent group of women who are unable to speak English. Their views are not incorporated in this study. Other researchers (Phillipson et al, 2004) have commented on the lack of English language skills as a reason for loneliness and isolation as it denies access to local health and welfare services (Pollen, 2002). Therefore it is essential to provide opportunities for wider social involvement for all Bangladeshi women.

During the study period with Bangladeshi women, it became clear that they were a progressive and ‘time tested’ group of people. The women in the study sample felt optimistic about their children’s future although there was apprehension about their lack of opportunities to take part in the wider social

environment, especially working together with the non-Bangladeshi community in the neighbourhood. A community teacher confirmed that in her opinion Bangladeshi women can participate more in activities related to local issues.

> Whenever we have a community or publicity event these women come in their best clothes and spend the whole day until the event is over. Their participation is extremely good; however we do not make use of their full potential to the best. I have seen them chatting to health workers during public health activities, but we don't approach them otherwise (Mary, community tutor).

Although the study sample was able to express their ideas in English, they were aware of their limited knowledge of English which kept them away from wider social involvement. Nevertheless, they are prepared to take new challenges. They also demonstrated their willingness to get involved in local events and activities. As discussed earlier, they wanted to look better and they were also aware of the stigma attached to their paan habit. They wanted to cease chewing paan for their health as well as for the sake of their children who did not approve of their mothers' habit. Using paan is an important marker of their age and gender related social identity. Nevertheless they do not expect their children to take up the paan habit; instead, they have made it possible for younger women to be educated, independent and progressive, but they themselves are viewed as 'traditional' as set in older ways and the stigma of paan use is part of their exclusion. It is not surprising they also indicated their wish for paan cessation; this indicates another characteristic of

their transformation. As Brah (1996: 18) pointed out, cultures are never static: they evolve through history, hence cultural reproduction is, in part a process of cultural transformation.

In summary, this chapter illustrated that paan use is tied into Bangladeshi women's biographical experience of difficulty and success, exclusion and the construction of home and place and making new social bonds. While it was not a practice that came with them, it is part of the past and part of the other world they have brought here. It has been an aspect of the flourishing of their social bonds, but also marks them as confined to a restricted role in the new social world of Tower Hamlets, while their families and girls in particular move towards new challenges. Nevertheless, their willingness for paan cessation gives a window of opportunity for the health professionals to design and deliver appropriate health interventions.

CHAPTER 7: CONCLUSION AND RECOMMENDATIONS

Introduction

The biographical narrative approach adopted in this research aimed to set women's use of paan in context. Within their biographical narratives, their use of paan takes on a meaning that is very specific to this group. While it was certainly true that the cultural context, traditional meanings and socialisation in a context where paan use was common and accepted for men and women was part of the background of their paan use, it would be wrong to simply depict this as a causal factor in their everyday use of paan. As was pointed out in the introduction, this is true of men and women from a broad range of Asian backgrounds and yet the prevalence of use in older Bangladeshi women is markedly higher. It is also interesting to note that the women themselves depicted their use as higher than that of women who had remained in Bangladesh. This was not a practice that women brought with them when they came to the UK and typically they began paan use some years after arriving here. The broader aim of this thesis was to explore paan chewing experiences among a group of older Bangladeshi women. The rationale for the study was the public health concern associated with the carcinogenic and addictive nature of paan and the lack of knowledge surrounding the user perspective. Both are important aspects of health promotion; however, until now paan use has been viewed through the dominant medical model, the scientific and pharmacological aspects of paan use.

Although understanding the fundamental features of addiction and carcinogenicity through basic biology is important in pharmacotherapy, the individual and group experiences of dependence can give vital information about the personal and social aspects of paan use. Therefore, at the start of the study three questions were posed (see page three).

Drawing on empirical research with older Bangladeshi women, this thesis has explored the nature of addiction from their point of view and the various contextual circumstances that have led to paan dependence. Among these circumstances were the migrational histories, health inequalities and their location in the borough of Tower Hamlets. In addition, as discussed throughout, these contextual factors and circumstances intersect with women's socioeconomic, ethnic, addictive and gendered identities and positions. All these aspects are important in developing a holistic understanding of the complexities associated with paan use among this marginalised group of women. This study offers an alternative approach to viewing paan use, that is complementary to the existing body of knowledge. This can inform both health professionals and public health authorities so that they will be able to design and deliver better and appropriate interventions for paan cessation.

In evaluating the aims and findings of this study, the conclusion is divided in to four sections; to what extent the finding was expected, a summary of the main areas of difference and agreement between the respondents, connections

between the findings and other research in the literature review and the way forward in terms of recommendations.

To what extent were the aims of the research fulfilled ?

Constructions of paan use in medical models can oversimplify or stereotype cultural practice, present the study group as homogenous, lose the dynamic and changing nature of practice, focus on culture while ignoring structural material aspects of health inequalities particularly where lifestyle change is viewed as necessary there is a tendency to individualise the issue. These were the challenges that this thesis tried to address by adopting a qualitative, narrative approach to a public health issue so that the issue of paan use and the identity of the paan user could be constructed in a unique and organic way. In chapter two acculturation is discussed as a way of explaining migrant health behaviors, however, this study group demonstrated the opposite of what one might expect - the practice of paan use is rooted in the social context of making the UK their home, rather than it only being a tradition that travelled with them.

Prior to this study there was no qualitative research related specifically to Bangladeshi women's perspectives of their paan use. Therefore initially, this study did not begin with clear expectations of what would emerge from an exploration of the significance of paan use in women's' lives. The first assumption made by this study was that while paan is established as addictive (due to the presence of tobacco), chewing paan is a socially accepted cultural practice amongst this group and therefore this may significantly reinforce its frequent use. The findings of the study highlighted

the existence of paan dependence which echoes the outcomes of earlier scientific research in other study populations mentioned in chapter two (see Bedi, 1996). While paan dependence is an expected outcome, this study used sampling criteria which included visual signs of paan use indicating a long term paan habit

However, as shown throughout this thesis, this study illustrated that the popular assumption that the social acceptance or the cultural norm attached to Bangladeshi ethnicity, is not the main reason for Bangladeshi women's use of paan. The narratives highlighted the complex nature of paan use which is embedded in their biographical journeys. As discussed in chapter two other researchers (Higginbottom, 2006: 585), have identified biographical trajectories that give rise to variations in health and ill-health experiences (see also: Karlsen and Nazroo, 2002 a and b). They have pointed out that health and ill-health experiences between and within ethnic groups are not simply determined by culture and ethnicity but, arise from the coalescence of complex factors such as migration, cultural adaptation, racism, reception by the host community, socio-economic influences and prevailing societal ideologies. Hence, the women's social and cultural context was central to their paan use and significantly influenced the beginning of paan use and the current status of continuity which is also facilitated by addiction due to tobacco and areca nut in the paan mixture.

Overall, the aims of the study have been largely achieved; however, there are some areas where the scope of research is limited. For example, there is no

comparison of experiences within the study sample with other Bangladeshi paan users (women) who cannot speak English. What the study attempts to do is highlight an important health issue among older Bangladeshi women that has been largely ignored despite the widespread awareness of harm related to areca nut and tobacco consumption. Although the sample is small, in-depth interviews revealed detailed lived experiences of the respondents which are crucial in understanding the complexities of paan use among this population.

The main areas of agreement and difference between the respondents

During this study it became clear that there were many individual differences and similarities among the study sample. The differences were mainly related to their life in Sylhet; family size, literacy levels at the age of marriage and other socio economic circumstances such as whether they were big land owners or had an average size (in their own words) home garden. There were differences in how successful their marriages had been. Also, though all were Muslim, they differed in the centrality of religion in their lives in relation to, for example maintaining strict halal rules around food. However, there were many similarities in their accounts relating to paan use such as their nostalgic memories about the home they left behind. Hence the biographical details were filtered in order to retain the most relevant narratives pertinent to the study. Despite the many individual differences among them, they agreed on many issues relating to their life experiences as migrants and their attitudes towards life in England. All the women agreed that they had a difficult life after migrating to England. Their activities were curtailed and they were confined to

stay indoors for a very long time until the children started primary education. Their isolation was intensified by their poor language skills during that period. While many worked, often within the home, the role of homemaker and mother was central to their lives. However, as the children grew up, the women learned English by talking to their children whose medium of conversation with other siblings had become English. Most of the women had attended English as a Second Language (ESL) class, organised by the local authority. Some of them are still continuing these classes and all the women agreed that girls should be educated and employed. All the women emphasised the value of education and mentioned the sacrifices they had made in order to get their children educated; this echoes with findings of other feminist writers (Kabeer, 2000: 179), who highlighted the Bangladeshi mothers' greater willingness to invest in their children's education and especially in valuing the education of young girls. They have much to be proud of and have achieved a great deal. Furthermore, the majority of study participants agreed that they would like to be engaged in either voluntary or part time work and be more helpful to the wider community. Those who had other domestic and family responsibilities agreed that getting involved with some work outside the home would be more interesting in terms of meeting new people.

Regarding the use of paan, all the participants agreed that their paan use started in England as an aspect of their growing sociality, an opportunity for shared time and pleasant ritual. Note this was an aspect of their ability to create belonging, become part of a supportive network and also a positive identity, though subsequently this developed into a severe craving and

individualized frequent use. Another area of agreement is their appreciation for the transformation of Tower Hamlets; despite the fact that their spouses are enthusiastic about retiring in Bangladesh and some have already done so, none of the participants showed a willingness to return to Sylhet on a permanent basis. Just as they have been able to create attractive homes, the Bangladeshi diaspora has flourished in Tower Hamlets. The most important and relevant agreement of this study is the willingness of the study participants to cease paan use, which suggests that there may be other women in Tower Hamlets who feel the same.

Connections between the findings and other research

Similar to the studies carried out over the last few decades (Greenhalgh, 1998; Graham, 1993) this study has emphasised the importance of understanding user perspectives when developing treatment strategies and made respondents' life styles, social networks, material possessions, biographical journeys and other relevant aspects of their experiences visible to the world. Furthermore, the study highlighted the inequalities of health care related to paan use among Bangladeshi women due to the absence of designated tobacco cessation strategies within the tobacco policies. As discussed in chapter two this has been raised earlier by other researchers (Sproston and Mindell, 2004). This study makes similar connections to other studies (Messina et al, 2013) that found contextual factors such as; stress, traditional health messages and health beliefs, lack of awareness of the health risks as potentially leading to chewing tobacco. Furthermore, the ambivalence women felt between their desire to cease paan and their inability

to abstain from chewing tobacco, a feature associated with psychoactive substance use, has been highlighted by other researchers (Kakde, 2012). The ambivalence is partly facilitated by physical and physiological dependence. There is indecisiveness between wanting to cease paan because of the harmful effects and undesirable appearance, and dependency embedded within a complex network of social interactions, biographical histories and consumer product availability. The study acknowledges this ambivalence as well as the physiological barrier that prevents attempts of cessation of paan altogether, for a better appearance and good health. The women in this study reported that the physical and physiological discomfort of withdrawal effects such as toothache, headache and anxiety prevent their numerous attempts to cease paan. These withdrawals not only prevented cessation attempts but also encouraged more regular use of paan; a kind of self medication in order to alleviate the physical and psychological discomfort. This is an example of how a substitution therapy such as NRT can be helpful at the beginning of the cessation plan. Medical understanding is important here in pointing out how significant the physiological aspects of dependence are – but equally it is important to know how dependence is experienced and understood by the women themselves as this is key to creating a programme that fits their needs. This indicates the importance of NRT, as recognised in other studies mentioned in chapter two (see Croucher et al, 2009). Also this information is very important for general practice and other health professionals to create understanding of the way paan use might affect well being and help-seeking behavior. Hence, this study will support and compliment a range of addiction research that found paan is addictive and

those who chew paan constantly are addicted. The data gathered during field work support the findings of other studies which showed that there are several paan products available in Asian shops. Earlier research (Longman et al, 2010) has reported the availability of smokeless tobacco in shops in South Asian neighbourhoods in England. Although there are no similar ethnographic studies on Bangladeshi women's paan use to compare with this study, this study has made connections with other sociological research related to health and illness discussed in chapter two. Departing from previous studies on paan addiction, this study offers an alternative way of viewing paan use from a user perspective. Hence, it complements the current pharmacotherapy treatment as a way forward in strategies related to paan cessation.

The way forward

The evaluation of present day paan cessation programmes has established the successful use of NRT in short term smokeless tobacco abstinence. Thus, the way forward for paan cessation is to integrate complementary strategies that can facilitate long term abstinence of paan use. The key issues identified as complementary to the existing substitution therapy can be split in to four areas; integrating appropriate intervention programmes of paan cessation, education and training for health professionals to understand paan chewing in its socio cultural context and from a user perspective, Paan cessation campaigns to raise awareness of the dangers and harm related to paan chewing and a reconsideration of national tobacco control policies to include all the issues related to paan chewing.

Integrating appropriate intervention programmes of paan cessation This study emphasises that consideration should be given to integrating interventions in order to achieve long term cessation of paan. Therefore, questions need to be asked about what kinds of further interventions or support can be followed up. The answers can be found in their narratives. The women in this study sample demonstrated that they were hard working, they admired social and financial freedom and were determined to encourage their children through higher education. By doing so, they have dispelled any myths or negative stereotypes associated with Bangladeshi women. Although considered a vulnerable group in terms of health inequalities the narratives indicated their willingness to be involved in wider social activities. This provides a window of opportunity to encourage them to participate in wider community and social activities while receiving substitution therapy to alleviate the discomforts of paan withdrawal. Their sociability and enjoyment of social situations indicates that creating a programme oriented towards peer support and group interaction as well as individualized health advice would be beneficial. For example, there are lunch clubs and day centres that they may like to attend, socialise or volunteer at during this process of intervention. However, getting involved in wider social aspects of the community may not be easy for some women. Personal, social and cultural circumstances such as transport, childcare responsibilities for grandchildren and various other issues may cause them to refrain from participation. Some of them may not even see the relevance of such activities. Therefore, it is important to address these issues when designing innovative client and community centred

intervention programmes. Building on the findings here, it may be useful to include women themselves in designing such interventions.

On a personal note, although the women in the study group are able to speak English, poor literacy limited their employment and volunteering opportunities. Although the study sample is an older group of people, the issue of language is an important aspect for other older and younger women who have migrated after marriage. Current English language provisions need to be extended in order to include all those women who have chosen Britain as their home. These are only a few examples; however a well organised programme for paan prevention along with community participation can be beneficial to this group of women. Hence, this study proposes that integrating a wider community participation programme with the pharmacotherapy may help provide a better chance of achieving long term paan cessation. Furthermore, to achieve success in such an innovative programme the health and social care professionals and the associated staff may need relevant education and training in issues related to paan use, dependence and cessation.

Education and training for health professionals

Education and training for health professionals is an integral part of all health promotion and prevention programmes. During the field work for this study it became clear that the awareness of paan related harm is limited among the majority of the health professionals who meet paan users in the primary and the secondary care setting. Health and social care professionals are generally aware of the harm related to tobacco; however, there is a lack of awareness

among health care workers as to the nature of the ingredients of paan and the socio cultural significance of paan use. This is an important issue as discussed earlier in the thesis; in addition to tobacco in the paan mixture, areca nut is addictive and carcinogenic in its own right (Warnakulasuriya et al, 2002) and, the harm related to slaked lime is well established in cancer research. In addition, as outlined above, an understanding of the social and cultural aspects of paan use, such as the way areca nut is used in religious rites within Hindu traditions or used in Ayurvedic medicine, is critical to the success of programmes . But just as important is recognition of the complex role of paan in user's lives, how important the stigma of paan use is and the positive aspects of sociality and ritual that is structured around paan. Therefore, it is important that health and social care workers understand, not only the paan related harm, but also the socio cultural issues, views, beliefs and meanings attached to paan use among specific populations such as Bangladeshi women. This will help them to assess, make referrals or make decisions on what is suitable for each individual and which intervention or combinations of interventions will be more effective. Those public health professionals who design interventions and health promotion programmes need to target and tailor different groups in terms of gender, ethnicity, religion, socioeconomic status and age. Therefore, they will be benefitted by education and training programmes related to paan prevention and cessation.

Campaigns to raise awareness of the harm related to paan chewing

Raising public awareness of the harm related to paan chewing needs to be done simultaneously with the treatment programme. As found during the field work, different groups such as users, paan vendors, trading standards officers, community organisers, teachers, faith leaders, researchers and health professionals of all levels seem to have different views about paan use. Thus, it is necessary to work with all these groups using a variety of client based information and communication techniques. It is also possible to tap into existing health promotion programmes and networks; for example stroke and cardiovascular disease prevention campaigns can incorporate paan cessation messages because paan chewing is a risk factor for both those conditions. Similarly, community events such as Bangla mela and Eid celebrations are vehicles for health promotion campaigns against paan chewing. Leaflets and posters written in English as well as in community languages can be distributed and displayed in schools, community centres, surgeries, adult education institutions and in mosques. Local papers Bangla television, internet and social media can provide ample opportunities to create awareness of paan related harm and encourage paan users to seek help from dedicated services. This study contends that it is necessary to raise awareness on a local level as well as on a national level.

Reconsider national tobacco control policies to include all the related issues

This study has demonstrated that there are key social and cultural aspects of everyday paan use that strong public health campaigns could engage with.

The findings of the research have, hopefully, given deeper insights into paan use among this group of women. However, this kind of qualitative small-scale study is of course very limited in terms of generalizability - paan use is also a public health issue amongst other groups and, importantly, other smokeless tobacco products that are available will continue to be a public health issue, and may well increase. This research and other studies appear to indicate that younger Bangladeshi groups are not attracted to paan, to creating paan mixture and quid themselves, to the social rituals relating to paan. There is also stigma associated with the staining of the mouth associated with frequent use and being identified as a paan user is unlikely to be an attractive prospect for the younger generation. However, the new products that are easy to buy and consume are potentially a serious health risk. Again, relatively little is known about how these are consumed and by whom, further the lack of regulation and the laxity of enforcement means that the commercial pressures driving the use of these products are opening up markets for them in the UK and elsewhere. This does need to be taken seriously. While the kinds of knowledge generated by this type of research are crucial to develop understanding of experience and improve practice, it is also important to maintain focus on dealing with the forces driving this issue, directing policy 'upstream'. It is all too easy to focus on the groups themselves as though they are the source of the problem, as discussed by this thesis, paan dependence is a multi-factorial issue. As Carro Ripaldo et al (2013) point out, Public health policy is frequently criticized for "lifestyle creep," that is, a "tendency for policy to start off recognizing the need for action on upstream social determinants of health inequalities only to drift downstream to focus

largely on individual lifestyle factors" (Popay, Whitehead and Hunter 2010: 148).

The findings of the study provide clear evidence that there is a need to reconsider national tobacco control policies to include all issues related to paan chewing and cessation strategies. The way paan use is addressed in current tobacco policies is likely to contribute to inequalities of health. Despite being recognised as a health risk, paan related issues are woefully neglected in both national and international tobacco policies (see DOH, 1999). Although the worldwide anti-smoking campaigns are proving to be successful, women's health due to oral tobacco is yet to be identified and addressed in the health policy agenda. While the global health concerns related to tobacco are being discussed, implemented and monitored by the WHO and the world governments, there is inadequate emphasis and recognition given to the health of women who use paan. In terms of inequalities of health, older Bangladeshi women's vulnerability is higher due to their excessive paan use and the lack of dedicated tobacco cessation treatment services for Bangladeshi women in the UK. The narratives of the women highlighted that the availability of paan products as a major cause for the beginning and continuing of their paan use. In addition there are numerous paan products available in Asian shops in Tower Hamlets (Islam et al, 1995). This needs to be recognised in the current health promotion practices funded by tobacco policies in England. Therefore, it is important that tobacco policies regulate all issues related to paan addiction.

In order to include all issues related to smokeless tobacco/paan, equal emphasis and consideration should be given to paan in national tobacco policies. First, the NHS Stop Smoking services should be extended to a stop tobacco altogether campaign. This includes funding public awareness campaigns, collecting data on tobacco chewing, conducting more research on paan and cessation programmes. Second, there should be enforcement of local and national level imports and sales of chewing (paan) tobacco. It is important to use the term 'paan' in policies to avoid any loop holes for misinterpretation due to terminology used with other paan products. Furthermore, all paan products need to clearly state the number of ingredients along with the health warnings emphasising the addictive and carcinogenic nature of the paan mixture. It could be even more effective to encourage and influence the WHO to reconsider its Framework Convention on Tobacco Control (FCTC) to have more emphasis on paan in terms of prevention, cessation and product regulation.

In conclusion, this study contends that although it may be impossible to change the circumstances that the study participants found themselves in and to redress all the factors that marginalise these women, it is possible to understand that the women's life experiences have shaped their paan use and, their current position and physical symptoms are important aspects that need to be taken into account. The medical professionals could use this information in the care of this group and offer much better support when they need care and ask for help in quitting paan chewing. This emphasises that a dedicated health promotion programme along with wider community

involvement of Bangladeshi women can help immeasurably in managing their tobacco dependence.

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APPENDIX

Picture 1: A bundle of betel leaves

Picture 2: Ripe areca nuts

Picture 3: Areca nut palm

Picture 4: Areca nut cutter

Picture 5: The most visible harmful aspect of betel chewing

Picture 6: Some paan products available in England

Picture 7: Tobacco-flavoured toffees

Picture 8: A scene on Brick Lane

Picture 9: East London mosque

Picture 10: Shops on the main street in Whitechapel.

Picture 11: Paan causes dental decay

Picture 12: Dental decay and lesions in the mouth of a tea plantation worker in Sri Lanka